GEORGIA STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

FILE NO. FOR STATE REGISTRAR

B.O.V.S. FORM 11

THIS IS A PERMANENT RECORD. WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. N.B.—In deaths from Violent Causes, State (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See Reverse Side for Additional Space.)

1 PLACE OF DEATH

COUNTY Franklin

MILITIA DISTRICT Strattys

TOWN OR CITY ______ No. ______ ST. REG. DIST. NO. 512 REGISTERED NO. 8

(IF DEATH OCCURRED IN HOSPITAL OR INSTITUTION, GIVE ITS NAME INSTEAD OF STREET AND NUMBER.)

2 FULL NAME Mary A. Nancy McDuffie

RESIDENCE, CITY ______ No. ______ ST. ______ (IF NON-RESIDENT GIVE CITY OR TOWN AND STATE)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ dys. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ dys.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 SINGLE, MARRIED, WIDOWED, DIVORCED (write the word) Married

5a IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6 DATE OF BIRTH, (MO. DY. YR.) Sep 1864

7 AGE 66 yrs. 4 mos. 25 dys. IF LESS THAN 2 YEARS state if breast fed Yes ___ No ___ IF LESS than 1 day ___ hrs. ___ mins.

8 OCCUPATION (a) TRADE, PROFESSION OR PARTICULAR KIND OF WORK Housekeeper (b) GENERAL NATURE OF INDUSTRY, BUSINESS OR ESTABLISHMENT IN WHICH EMPLOYED (OR EMPLOYER)

PARENTS

9 BIRTHPLACE (STATE OR COUNTRY) Ga

10 NAME OF FATHER David Waggoner

11 BIRTHPLACE OF FATHER (STATE OR COUNTRY) Ga

12 MAIDEN NAME OF MOTHER Don't Know Gillespie

13 BIRTHPLACE OF MOTHER (STATE OR COUNTRY) " "

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(INFORMANT) Hoyt McDuffie

(ADDRESS) Ashland Ga

15 FILED 4/30 193_ J. C. Dalrymple LOCAL REGISTRAR

MEDICAL PARTICULARS

16 DATE OF DEATH Feb 10 1938

17 I HEREBY CERTIFY, THAT I ATTENDED DECEASED FROM Feb 1 1938, TO Feb 10 1938

THAT I LAST SAW H(er) ALIVE ON Feb 10 1938

AND THAT DEATH OCCURRED, ON THE DATE STATED ABOVE, AT 10 P M. THE CAUSE OF DEATH WAS AS FOLLOWS:

Pneumonia

(DURATION) ___ YRS. ___ MOS. 4 DYS.

CONTRIBUTORY (SECONDARY)

(DURATION) ___ YRS. ___ MOS. ___ DYS.

WHERE WAS DISEASE CONTRACTED, IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? ___ DATE OF ___

WAS THERE AN AUTOPSY? ___ WHAT TEST CONFIRMED DIAGNOSIS? [illegible]

(SIGNED) L. M. Baker M.D. M.D.

[illegible] 193_ (ADDRESS) Carnesville Ga

19 PLACE OF BURIAL, CREMATION, OR REMOVAL New Bethel | DATE 2/14

20 B.O. Ginn UNDERTAKER | Carnesville Ga ADDRESS