

CERTIFICATE OF DEATH, CITY OF ATLANTA

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
 County Fulton State Ga Registered No. 1011
 Township _____ or Village _____
 City Atlanta No. _____ St. 230 Ward 5
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Joel Chandler
 (a) Residence No. 8 Agate ave St. _____ Ward _____
(Total place of abode)
 Length of residence in city or town where death occurred yrs. _____ mos. _____ ds. Date born in _____ mo. _____ day _____ year _____

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Sexes, Marriages, Widows or Divorces (in this order)
Married
 6a If married, widowed, or divorced
 HUSBAND of _____
 (or) WIFE of _____
 7 DATE OF BIRTH (month, day, and year) Nov 7-1890
 7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. _____ min. _____ sec.

8 OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (as employer) _____
 (c) Name of employer _____

9 BIRTHPLACE (city or town) Ga
 (State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) _____
 (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (City or town) _____
 (State or country)

14 Informant (Address) Mrs. H. J. Evans
8 Agate Ave

15 Filed May 23 1918

MEDICAL CERTIFICATE OF DEATH

15 DATE OF DEATH (Month, day, and year) May 21 1918
 17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1918 to May 21 1918
 that I last saw him alive on May 21 1918
 and that death occurred, on the date stated above, at 1440 am

The CAUSE OF DEATH* was as follows:
Leucemia
 (duration) 3 yrs. 6 mos. _____ ds.
 CONTRIBUTORY (Secondary) _____
 (duration) _____ yrs. _____ mos. _____ ds.
 18 Where was disease contracted _____
 If not in place of death from 3 months
 Did an operation precede death? No Date of _____
 Was there an autopsy? No
 What test confirmed diagnosis? _____
 (Signed) H. J. Carter M. D.
 19 (Address) Pr. 327 H. J. Carter

* State the DISEASE CAUSING DEATH, or its origin from VIO-
 LENT CAUSES, name of MEANS and DATE OF INFECT, and
 (b) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL (See re-
 marks side for additional space)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Graceland, Ga

DATE OF BURIAL 5/23 1918

20 UNDERTAKER James B. Rose

ADDRESS Atlanta

Registrar

I hereby certify that the foregoing is a true and correct copy of the above certificate as appears on file in the office of Vital Statistics of Fulton County, Georgia.

Signed at Atlanta, Georgia, this _____ day of _____ 1918.

J. H. McPherson
 Registrar of Health
 Fulton County, Georgia

This certificate should be filled EXACTLY. PHYSICIAN, if possible, should fill it. If not, it may be properly filled. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

IMPORTANT—This Certificate will not be accepted unless all blanks are properly filled. Signature of Informant is very important.