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MISSISSIPPI STATE BOARD OF HEALTH

Bureau of Vital Statistics — CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Copiah State Miss Registration District No. _____ File No. _____

Village Gallman Vot. Pct. _____ or Primary Registration Dist. No. _____ Reg. No. _____

City _____ No. _____ St., _____ Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Tom Hartley

(a) Residence No. _____ St., _____ Ward, _____

(Usual place of abode) (If non-resident give city or town and state.)

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Mal	Col	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of)

6 DATE OF BIRTH (month, day and year)

7 AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ___ hrs. or ___ min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lincoln Co Miss

PARENTS

10 NAME OF FATHER Bob Hartley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Miss

12 MAIDEN NAME OF MOTHER Dot Knox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Miss

14 Informant John Hartley Jr

(Address) Gallman Rt 2

15 Filed 1-29, 19 26 J C Ramsey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month, day and year) Jan 20 19 26

17. I HEREBY CERTIFY, That I attended the deceased from 12-1-25, 19___, to 1/28, 19 26, that I last saw h[illegible] alive on 1-1-, 19 26 and that death occurred on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

1 Chronic Pulmonary Tuberculosis

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

Signed Jno Gberson M. D.

1-29-26 (Address) C. Springs

*State the Disease Causing Death, or 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.)

19 Place of Burial, Cremation or Removal	Date of Burial 1-30 19 26
20 UNDERTAKER Wayne	ADDRESS

Form V. S. No. 1

N. B. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. 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. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

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STATE OF MISSISSIPPI

STATE BOARD OF HEALTH
Bureau of Vital Statistics

CERTIFICATE OF DEATH

7491

1 PLACE OF DEATH

County Copiah

Vot. Pct. Gallman

Inc. Town or Village or City

Registration District No. 212 File No.

Primary Registration District No. 8320 Registered No.

(No. , St.; Ward)

If death occurred in a hospital or institution give its NAME instead of street and number.

2 FULL NAME Sarah Hartley

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR or RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Fem	Negro	Married

6 DATE OF BIRTH Feb Unknown, 1 (Month, Day, Year)

7 AGE 37 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housekeeping
(b) General nature of industry, business, or establishment in which employed, (or employer)

9 BIRTHPLACE (State or Country) Lincoln

PARENTS

10 NAME OF FATHER Richard Coleman

11 BIRTHPLACE OF FATHER (State or Country)

12 MAIDEN NAME OF MOTHER Rosa Irvin

13 BIRTHPLACE OF MOTHER (State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clarence Coleman

(Address) Gallman Miss

15 Filed, 191 W. R. Allen Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 17, 1914 (Month, Day, Year)

17 I HEREBY CERTIFY, That I attended the deceased from 4/13, 1914, to 5/12, 1914, that I last saw her alive on 5/12, 1914, and that death occurred on the date stated above, at 8 pm.

The CAUSE OF DEATH * was as follows:

Edema of Lungs

(4)

Duration yrs. mos. 14 ds.

Contributory Malaria.
SECONDARY

Duration yrs. 1 mos. 10 ds.

Signed E. E. Busby, M. D.

5/13, 1914 Address Gallman Miss

*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At Place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Gallman DATE OF REMOVAL , 191

20 UNDERTAKER Brumfield & Son ADDRESS Gallman

Form V. S. No. 4. 75 M. 6-27-12. T.