STATE OF MISSISSIPPI

STATE BOARD OF HEALTH
Bureau of Vital Statistics
CERTIFICATE OF DEATH

3270

1 PLACE OF DEATH
County Lincoln
Vot. Pct.
Inc. Town or Village or
City Brookhaven (No. , St., Ward)

Registration District No. 491
Primary Registration District No. 2366
File No.
Registered No. 21

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

2 FULL NAME Will Jones

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR or RACE: Negro
5 SINGLE, MARRIED, WIDOWED, or DIVORCED (Write the word): married

6 DATE OF BIRTH
Month Day Year

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

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Oil mill
(b) General nature of industry, business, or establishment in which employed, (or employer): common Labor

9 BIRTHPLACE (State or Country)
Mississippi

PARENTS

10 NAME OF FATHER: Dont Know
11 BIRTHPLACE OF FATHER (State or Country): Dont Know
12 MAIDEN NAME OF MOTHER: Dont Know
13 BIRTHPLACE OF MOTHER (State or Country): Dont Know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Tom Woodruff
(Address) Brookhaven

15
Filed 2/19/1917 J H Johnson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 19 1917
Month Day Year

17 I HEREBY CERTIFY, That I attended the deceased from Dec 19 to Feb 19 1917
that I last saw him alive on 191
and that death occurred on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:

Pellagra

about 2 Yrs
Duration yrs. mos. ds.
Contributory Secondary
Duration yrs. mos. ds.

Signed W. H. Bizzell M. D.
2/19 1917 Address Brookhaven

* 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: Rose Hill
DATE OF BURIAL: 2/19 1917

20 UNDERTAKER: Home Furniture Co
ADDRESS: B Haney

Form V. S. No. 4. 25M-11-8-16-H.

N. B.—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

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD