

DEPARTMENT OF PUBLIC HEALTH **CERTIFICATE OF DEATH** DIVISION OF VITAL STATISTICS  
STATE OF TENNESSEE

2381  
21  
2300  
BIRTH NO.

DEATH NO. 63-111700

1. NAME <i>Minnie French</i>		2. DATE OF DEATH <i>Jan. 1, 1963</i>	
3. COLOR OR RACE <i>White</i>		4. SEX <i>Female</i>	
5. SINGLE, MARRIED, WIDOWED, DIVORCED (SPECIFY) <i>Married</i>		6. DATE MONTH DAY YEAR OF BIRTH <i>Oct. 23, 1891</i>	
7. AGE (IN YEARS) LAST BIRTHDAY <i>71</i>		8. IF UNDER 1 YR. MONTHS DAYS	
9. IF UNDER 24 HRS. HOURS MINS.		9. USUAL RESIDENCE OF DECEASED (Where Deceased Lived, If Institution, Residence Before Admission)	
A. COUNTY <i>Dyer</i>		A. STATE <i>Tenn</i> B. COUNTY <i>Dyer</i> C. CIVIL DISTRICT <i>17</i>	
D. CIVIL DISTRICT <i>4</i>		D. CITY OR TOWN <i>Lenox</i>	
E. NAME OF HOSPITAL OR INSTITUTION (If not in Hospital or Institution, Give Street Address or Location) <i>Parkview Hospital</i>		F. STREET ADDRESS (OR LOCATION) <i>Rural Route</i>	
G. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		G. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10A. USUAL OCCUPATION (Kind of Work Done During Most of Working Life, Even if Retired) <i>At Home</i>		10B. KIND OF BUSINESS OR INDUSTRY	
11. SOCIAL SECURITY NUMBER		12. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO, OR UNKNOWN	
13. BIRTHPLACE (State or Foreign Country) <i>Tennessee</i>		14. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. NAME OF HUSBAND OR WIFE <i>Mr. A. R. French</i>		16. FATHER'S NAME <i>Tom French</i>	
17. MOTHER'S MAIDEN NAME <i>Unknown French</i>		18. INFORMANT ADDRESS <i>Mr. A. R. French - Lenox, Tennessee</i>	
19. CAUSE OF DEATH (Enter only one cause per line for (A), (B), (C))			INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (A) <i>Congestive Heart Failure 4341</i>			<i>3 days</i>
DUE TO (B) _____			
DUE TO (C) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO TERMINAL DISEASE CONDITION GIVEN IN PART I (A)			20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		21B. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 19)	
21C. TIME OF INJURY: HOUR MO. DAY YR. A.M. P.M.		21E. PLACE OF INJURY (In or About Home, Farm, Factory, Street, Office Building, etc.)	
21D. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. PLACE OF INJURY CITY, TOWN OR RURAL COUNTY STATE	
22. I HEREBY CERTIFY THAT THE DECEASED DIED ON THE DATE AND FROM THE CAUSE STATED ABOVE			
SIGNATURE <i>George W. Shelton</i>		M.D. D.O. OTHER (SPECIFY) <input checked="" type="checkbox"/> <input type="checkbox"/>	
ADDRESS <i>Dyersburg Tenn</i>		DATE <i>1-5-63</i>	
23A. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23B. DATE OF BURIAL, CREMATION, OR REMOVAL <i>Jan. 2, 1963</i>	
23C. NAME OF Cemetery or Crematory <i>Memorial Gardens</i>		23D. LOCATION CITY, TOWN OR COUNTY STATE <i>Dyer Co. Tennessee</i>	
24. FUNERAL DIRECTOR ADDRESS <i>J. W. Curry &amp; Son, Dyersburg, Tennessee</i>		25. REGISTRATION DIST. NO. <i>22304</i>	
26. DATE SIGNED BY <i>Jan 4, 1963</i>		27. REGISTRAR'S SIGNATURE <i>W. J. Shelton</i>	

THIS BECOMES A LEGAL RECORD WHEN PROPERLY EXECUTED AND WILL BE PLACED IN PERMANENT FILE.

TYPE OR WRITE PLAINLY. ONLY PERMANENT BLUE OR BLACK INK ACCEPTABLE. SIGNATURE MUST BE IN PERMANENT BLUE OR BLACK INK.

PHYSICIAN WHO ATTENDED DECEASED DURING LAST ILLNESS MUST GIVE WELL-DEFINED CAUSE OF DEATH AND SIGN MEDICAL CERTIFICATION. ANY PHYSICIAN, COUNTY HEALTH OFFICER OR CORONER EXECUTING CERTIFICATE MUST COMPLETE AND SIGN MEDICAL CERTIFICATION WITHIN 72 HOURS OF SIGNATURE NOT BE DELEGATED.

CAUSE OF DEATH. DO NOT WRITE IN THIS SPACE. COMPLETE CAUSE OF DEATH.

FUNERAL DIRECTOR SIGNATURE AND ADDRESS WITHIN 72 HOURS AFTER DEATH AND PRIOR TO REMOVAL FROM STATE.

ALL ITEMS ARE TO BE COMPLETE AND ACCURATE.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE - PUBLIC HEALTH SERVICE