B.V.S.—Form 7

NORTH CAROLINA STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

Ext Report

1 PLACE OF DEATH Registration District No. [illegible] Register No. 837

County Buncombe State North Carolina

Township [illegible] or Village Oteen, or

City ____ No. U. S. Army General Hospital No. 19, St. ____ Ward

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

2 FULL NAME Noel Johnson. 523 33937

(a) Residence. No. ____ St. ____ Ward. ____

(Usual place of abode) (If nonresident 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)
Male	White	Single

5a If married, widowed, or divorced
Husband of
(or) Wife of XXXXX

6 Date of birth (month, day, and year) XXXX

7 Age years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
28	XXX	XXX	

8 Occupation of deceased

(a) Trade, Profession, or particular kind of work Student (Soldier)

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

(c) Name of employer XXXXXX

9 Birthplace (city or town) ____
(State or country) XXXXXXXX

Parents

10 Name of Father XXXXXXXX

11 Birthplace of Father (city or town) ____
(State or country) XXXXXXX

12 Maiden Name of Mother XXXXX

13 Birthplace of Mother (city or town) ____
(State or country) XXXXXXX

14 Informant Clinical Record.
(Address)

15 Filed [illegible] 19 19 M. McFee
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 Date of Death (month, day, and year) Nov. 9th 1919.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15th, 1919, to Nov. 9th, 1919, that I last saw him alive on Nov. 9th, 1919, and that death occurred, on the date stated above, at 6:45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

28

(duration) ____ yrs. 11 mos. ____ ds.

Contributory (SECONDARY) XXXX

(duration) ____ yrs. ____ mos. ____ ds.

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

Did an operation precede death? No. Date of ____

Was there an autopsy? No.

What test confirmed diagnosis? ____

(Signed) O. K. Emerson, 1st Lt., M. C., M.D.

11-9-1919 (Address) U. S. A. G. H. No. 19, Oteen, N. C.

*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
Cove, Polk Co. Ark.	19
20 Undertaker	**Address**
Hare & Reynolds.	

...mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN 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.