

96-80

This is a legal record and will be permanently filed.

Type or write legibly. Use black ink.

1-F

5-00

All items must be complete and accurate.

2

The undertaker, or person acting as such, is responsible for filing the completed certificate with registrar of the district where death occurred.

The physician last in attendance is required to state the cause of death and sign the medical certification.

If there was no doctor in attendance, medical certification to be completed by local Health Officer (or Coroner, if inquest was held).

FORM 8
Rev. 1-49Birth No. 128
JAN 11 1955

REGISTRATION DISTRICT NO. 54-80 REGISTRAR'S CERTIFICATE NO.

NORTH CAROLINA STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHDr Tom Parson
29513

1. PLACE OF DEATH, a. COUNTY <i>Alamance</i>		b. TOWNSHIP	c. LENGTH OF STAY (in this township) <i>3 months</i>	2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>N.C.</i>		b. COUNTY <i>Alamance</i>
4. CITY OR TOWN <i>Hurston N.C.</i>		In Place of Death Within City Limits? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		c. CITY OR TOWN <i>Hurston N.C.</i>		In Place of Residence Within City Limits? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>Parrott M. Hospital</i>			d. STREET ADDRESS or R. F. D. NO. <i>615 west Pine St.</i>			
2. NAME OF DECEASED a. (First) <i>Joseph Benjamin</i>			b. (Middle) <i>Deann</i>		c. (Last) <i>Deann</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <i>Married</i>		8. DATE OF BIRTH <i>9-13-1887</i>
9. AGE (In years last birthday) <i>67</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Merchant</i>		11. BIRTHPLACE (State or foreign country) <i>Duplin County, N.C.</i>		12. CITIZEN OR WHAT COUNTRY <i>USA</i>
13. FATHER'S NAME <i>Joseph Green Deann</i>			14. MOTHER'S MAIDEN NAME <i>Cora Hill</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT'S NAME AND ADDRESS <i>Joseph Astor Deann Myerville</i>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. <i>4-2-54</i>		19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Arteriosclerotic heart disease</i> ANTECEDENT CAUSES DUE TO (b) <i>Maribid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Heart failure</i>			INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		19c. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. THE INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <i>13 Sept 1954</i> to <i>23 Dec 1954</i> , that I last saw the deceased alive on <i>23 Dec 1954</i> and that death occurred at <i>7:30 A.M.</i> from the causes and on the date stated above.						
23a. SIGNATURE (Degree or title) <i>W. T. Parson, M.D.</i>			23b. ADDRESS <i>Hurston N.C.</i>		23c. DATE SIGNED <i>28 Dec 54</i>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremial</i>		24b. DATE <i>12-24-54</i>		24c. NAME OF CEMETERY OR CREMATORY <i>West View Cemetery</i>		24d. LOCATION (City, town, or county) (State) <i>Hurston N.C.</i>
DATE REC'D BY LOCAL JAN 3 1955		REGISTRAR'S SIGNATURE <i>R. J. Jones M.D.</i>		25. GENERAL DIRECTOR ADDRESS <i>James F. Hone Hurston N.C.</i>		

THIS COPY FOR STATE BOARD OF HEALTH