

CERTIFICATE OF DEATH  
GEORGIA DEPARTMENT OF PUBLIC HEALTH

State File No. \_\_\_\_\_  
29104  
L. R. File No. 814

203 #1-100M-5-3-41

1. Place of Death  
(a) County DeKalb Militia Dist. No. \_\_\_\_\_  
(b) City or Town Brookhaven  
(If Outside City or Town Limits, Write Rural)  
(c) Name of Hosp. or Institution 226 Peachtree View  
(d) Length of Stay Before Death: Hosp. or Institution \_\_\_\_\_ In This Community 37 yrs.

2. Usual Residence of Deceased  
(a) State Ga. (b) County DeKalb  
(c) City or Town Brookhaven  
(If Outside City or Town Limits, Write Rural)  
(d) R.F.D. and Box No. 226 Peachtree View  
(e) Citizen of Foreign Country? \_\_\_\_\_ (Yes ) If Yes, Name or No Country \_\_\_\_\_

3. Name John Wesley Hairston If Veteran Name War \_\_\_\_\_ Social Security Number \_\_\_\_\_

PERSONAL AND STATISTICAL PARTICULARS

4. Sex Male 5. Race White Marital \_\_\_\_\_ S. M. \_\_\_\_\_  
6. Status (circle) W. D.  
7. Give Name of Spouse \_\_\_\_\_  
8. Age Years 37 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than 24 hrs. Hrs. \_\_\_\_\_ Min. \_\_\_\_\_

9. Birth Date of Birth 4-18-04 Birth Place Atlanta, Ga.  
Mo. Day Year

10. Usual Occupation W. P. A. Clerk

11. Industry or Business \_\_\_\_\_ 9m

12. Name R. Reid Hairston  
13. Birthplace Atlanta, Ga.

14. Name Artie Missy Hollingsworth  
15. Birth Place Atlanta, Ga.

16. Own Signature [Signature]  
17. Informants P. O. Address 226 Peachtree View.

18. Burial, Cremation or Removal Burial (a) Date 12-15/41

19. P. O. Address of Place of Burial West View, Atlanta Ga.

20. Signature of Person Burying Body H. M. Patterson & Son  
Date Filed with L. R. \_\_\_\_\_

21. P. O. Address of Undertaker Atlanta, S. Bowen DEC 15 1941

22. Registrar's Own Signature [Signature]  
(Check Certificate Carefully Before Signing)

MEDICAL CERTIFICATION

23. Date of Death 12-13-41 Time ? A. M. P. M. (Hour : Minute)

24. I hereby certify that I attended the deceased who died on the above date. I last saw \_\_\_\_\_

H \_\_\_\_\_ Alive on \_\_\_\_\_ 19 \_\_\_\_\_

Primary Cause of Death \_\_\_\_\_

(Please Underline the Cause to Which This Death Should Be Charged)

Contributory Causes [Handwritten]

(Including Any Pregnancy Within Three Months of Death)

Operation \_\_\_\_\_ Date of Operation \_\_\_\_\_ Diagnosis: Clinical, Lab., X-Ray (Check) \_\_\_\_\_ Was Autopsy Performed: \_\_\_\_\_

25. If death was due to external violence please answer the following questions:

(a) Accident, Suicide Homicide (Specify) \_\_\_\_\_ (b) Date of Occurrence \_\_\_\_\_

(c) Place of Accident \_\_\_\_\_ (City) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_

(d) Where: Home, Farm, Industry, Public Place \_\_\_\_\_ While at Work \_\_\_\_\_

(e) Means of Injury Heart attack cause unknown

26. Physician's Own Signature [Signature] Date Signed 12/13/41

Physician's P. O. Address [Signature]

Please answer carefully all questions to avoid receiving queries for omitted information. Please give age, occupation and Social Security No. to assist in settling S. S. claims.