

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

41

**1 PLACE OF DEATH** Registration District No. 29-221  
 County Dawson State NC Register No. 2  
 Township Leighton or Village \_\_\_\_\_ or \_\_\_\_\_  
 City Leighton No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (If death occurred in a hospital or institution, give its name instead of street and number)  
**2 FULL NAME** Ed Cape  
 (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** Male **4 Color or Race** White **5 Single, Married, Widowed, or Divorced** (write the word) Married  
**5a If married, widowed, or divorced**  
 Husband of \_\_\_\_\_  
 (or) Wife of \_\_\_\_\_

**6 Date of Birth** (month, day, and year) Dec 13-1898

**7 Age** years 28 Months \_\_\_\_\_ Days 17 If LESS than 1 day, hrs. or min. \_\_\_\_\_

**8 Occupation of deceased**  
 (a) Trade, Profession, or particular kind of work Scrub  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

**9 Birthplace** (city or town) Dawson  
 (State or country) \_\_\_\_\_

**10 Name of Father** Ed Cape

**11 Birthplace of Father** (city or town) Dawson  
 (State or country) \_\_\_\_\_

**12 Maiden Name of Mother** Mary Neely

**13 Birthplace of Mother** (city or town) Dawson  
 (State or country) \_\_\_\_\_

**14 Informant** Mrs Ed Cape  
 (Address) Leighton NC

**15 Filed** 2/4-1926 Margaret Brillee  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16 Date of Death** (month, day, and year) 1-1-1926

**17**

I HEREBY CERTIFY, That I attended deceased from 1-1-1926 to 1-1-1926, 1926  
 that I last saw him alive on 1-1-1926  
 and that death occurred, on the date stated above, at 12:00 A.M.

The CAUSE OF DEATH\* was as follows:  
Fractured Skull.  
Thrown from fire truck while on duty. Truck turned over after a collision with car on street  
 (duration) yrs. 11 mos. \_\_\_\_\_ ds. \_\_\_\_\_

**18 Where was disease contracted** yes  
 if not at place of death? \_\_\_\_\_

Did an operation precede death? no Date of \_\_\_\_\_

Was there an autopsy? no

What test confirmed diagnosis? Phys. exam  
 (Signed) [Signature] M. D.  
1-16-1926 (Address) Leighton NC

\*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** Shila Date of Burial 1-3-1926

**20 Undertaker** O.A. Finckelbein Address 24 N.C.

Information 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.