

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
STATE CENTER FOR HEALTH STATISTICS — N. C. VITAL RECORDS
CERTIFICATE OF DEATH

Registration District No. 006-00 Local No. 79

DECEDENT'S NAME (First, Middle, Last) LILLIE BELLE CLAWSON		SEX F	DATE OF DEATH (Month, Day, Year) APRIL 30, 1999
SOCIAL SECURITY NUMBER 344-30-5814	AGE—Last Birthday (Years) 63	DATE OF BIRTH (Month, Day, Year) 9-3-1935	BIRTHPLACE (County and State or Federal Country) CARTER CO. TN
WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or No) NO		PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
FACILITY NAME (If not institution, give street and number) 14 PINE CLUSTER LN		CITY, TOWN, OR LOCATION OF DEATH PINEOLA	COUNTY OF DEATH AVERY
MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify) MARRIED	SURVIVING SPOUSE (If wife, give maiden name) ALGIE CLAWSON	DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) SECRETARY	KIND OF BUSINESS/INDUSTRY PHARMACEUTICAL CO.
RESIDENCE—STATE NC	COUNTY AVERY	CITY, TOWN, OR LOCATION PINEOLA	STREET AND NUMBER 14 PINE CLUSTER LN
INSIDE CITY LIMITS? (Yes or No) NO	ZIP CODE 28662	Was Decedent of Hispanic Origin? (Specify Yes or No—If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No (Specify)	RACE—American Indian, Black, White, Etc. (Specify) WHITE
FATHER'S NAME (First, Middle, Last) JOHN HARDIN POTTER		MOTHER'S NAME (First, Middle, Maiden Surname) STELLA MAE TURBYFILL	
INFORMANT'S NAME (Type/Print) LUCILLE HOLTSCLAW		MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO BOX 221 PINEOLA, NC 28662	DATE AMENDED 19c.
Part I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. If appropriate, enter tobacco, alcohol, or drug use. List only one cause on each line. (PRINT or TYPE)			Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Metastatic lung cancer DUE TO (OR AS A CONSEQUENCE OF):			6 months
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST. b. _____ DUE TO (OR AS A CONSEQUENCE OF):			
c. _____ DUE TO (OR AS A CONSEQUENCE OF):			
d. _____ DUE TO (OR AS A CONSEQUENCE OF):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, such as tobacco, alcohol, or drug use; diabetes, etc.			
AUTOPSY? (Yes or No)		Was case referred to Medical Examiner? (Yes or No)	TIME OF DEATH
NO		NO	7:40p M.
NOTICE: STATE LAW REQUIRES THAT ALL DEATHS DUE TO TRAUMA, ACCIDENT, HOMICIDE, SUICIDE, OR UNDER SUSPICIOUS, UNUSUAL, OR UNNATURAL CIRCUMSTANCES BE REPORTED TO AND CERTIFIED BY A MEDICAL EXAMINER ON A MEDICAL EXAMINER'S CERTIFICATE OF DEATH. ANY DEATH FALLING INTO THESE CATEGORIES IS WITHIN THE MEDICAL EXAMINER'S JURISDICTION REGARDLESS OF THE LENGTH OF SURVIVAL FOLLOWING THE UNDERLYING INJURY.			
SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		DATE SIGNED (Month, Day, Year) May 4, 1999	
NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 20) (Type or Print) Dr. Joseph Barker PO BOX 130, Crossnore, NC 28616			
METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal <input type="checkbox"/> Donation <input type="checkbox"/> Other		PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) TAYLOR'S CHAPEL CEMETERY	LOCATION—City or Town, State, Zip Code ELK PERK, NC 28622
NAME AND ADDRESS OF FUNERAL HOME REINS STURDIVANT POB 215 NEWLAND, NC		SIGNATURE OF FUNERAL DIRECTOR GARRICK SMITH	LICENSE NUMBER 1034
REGISTRAR'S SIGNATURE <i>Thomas L. Slight (jr)</i>	DATE FILED (Month, Day, Year) 05-06-99	SIGNATURE OF EMBALMER GARRICK SMITH	LICENSE NUMBER 1034

DECEDENT

PARENTS

INFORMANT

CAUSE OF DEATH

CERTIFIER

DISPOSITION

DHHS 1872
(Revised 11/97
Review 2/99)
VITAL RECORDS

STATE OF NC
OFFICE OF REGISTER OF DEEDS AVERY CO. NO
A TRUE CERTIFIED AND COMPLETE COPY
AS RECORDED IN THIS OFFICE.
VOID IF ANY ALTERATIONS APPEAR

BY *[Signature]*
ASSISTANT DEPUTY

REGISTER OF DEEDS,
TEL. AREA CODE (919) 733-8260

FILED

APR 2 2000

PETER BENJAMIN
DAKE COUNTY AUDITOR

Mail to:
Algie Clawson
P.O. Box 322
Crown Point, NV 4637

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E.P.
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