Chattanooga, Tennessee

A (May be filled in by Agent, but must be signed by Applicant.)

1. Give FULL NAME of applicant.
DOROTHY M. SAMS

2. RESIDENCE. a. No. 501 VINE . Street APT. 4 | b CITY CHATTANOOGA

c COUNTY HAMILTON | d STATE TENN.

3. Date of birth Yr. 1921 Mo. OCT Day 8 | 4. Age nearest birthday 14 | 5. Birth Place N. C.

6. Race WHITE | 7. Married or single SINGLE | 8. Male or Female FEMALE | 9. Kind of policy desired ORD. LIFE END. 85

10. Amount 500.00 | 11. Premium $ 6.15 Payable ANN.

12. OCCUPATIONS, name them
SCHOOL

13. Employer DICKERSON JR. HIGH | 14. Kind of business STUDENT

15. BENEFICIARY (to whom the insurance shall be payable, subject to provisions in policy.)
a Full Name DR. A. B. SAMS | b Residence City CHATTANOOGA State TENN.
c Occupation OPTOMETRIST | d Relationship GRANDFATHER | e Age 70

16. Have you ever applied for new insurance or reinstatement of old insurance, on your life to any Life Insurance Company, Society, order or Association and your application been rejected, postponed or rated up on account of impairment? If so, give full particulars.
NONE

16a. Home Office corrections or additions
FULL NAME OF BENEFICIARY
ANSON B. SAMS

17. If you are now, or ever were, insured by this Company, give particulars below.

a Policy No.	b Year issued	c Amount of Insurance	d If cancelled, when and why?
NONE			

18. List below and give particulars about all policies now in force on your life with other Companies, Societies, Orders or Associations.

a Company	b. Year issued	c Amount of Insurance	d Kind of Policy?
		$	

19. **I hereby declare** the statements given above to be full, true and correct, and I hereby apply to **the Interstate Life & Accident Company** for the insurance described above. I agree that the Company shall incur no liability under this application until it shall have been duly received, approved and the policy issued and delivered to me by the Company and the first premium paid by me to and accepted by the Company during my good health. I hereby agree that my acceptance of any policy issued on this application, whether or not upon the form applied for herein, will constitute a ratification by me of any change, in the form of the policy, or correction in or addition to the application, made by the Company in the space above headed "Home Office Corrections and Additions," photographic or typewritten copy of which constitutes sufficient notice to me of the change made.

Witness to signature of Applicant:
L W RHODES Agent.

DR. A. B. SAMS (Signature of Applicant.)

Form L-1

RY

ate.)

tent herewith and I direct that
32921, issued by the
n my life be paid, subject to
ereof, to
iat of Father.

te a new beneficiary subject to
nooga, Tenn.

he 7th day

Dorothy M. Sams
Signature of Insured.

Anson B. Sams
Beneficiary

March 19 41.

ate Life & Accident Company

J. R. Lee
Secretary

RIAGE

(Note: This form must be executed in duplicate.)

Since Policy Number 32921 was issued to me by the **Interstate Life & Accident Company,** Chattanooga, Tenn., I have been married, and now request an endorsement on the Policy recognizing the change of my name.

My former name was Dorothy M. Sams

My present name is Dorothy Sams Askins

FORM FOR CHANGE OF BENEFICIARY

Form L73

DOROTHY M. SAMS 14

3. Date of Birth	4. Exact height	5. Weight	6. Sex	7. Race
Yr. 1921 Mo. OCT Day 8	Ft. 5 In. 2-1/2	112 lbs.	FEMALE	WHITE

8. Occupation, name them all: SCHOOL

9. Is applicant in sound health? YES

10. a Is Applicant ruptured? b If so, does he wear a well fitting truss? NO

11. Is Applicant blind, deaf or dumb, or has he any physical or mental defects of any kind? NO

12. To what extent does Applicant use alcoholic stimulants? NO

13. Give names and addresses of ALL physicians who have attended Applicant within two years, when and for what diseases and complaints? NO

14. Has Applicant ever had any of the following Diseases or Complaints? Answer YES or NO.

Apoplexy NO	Disease of Heart NO	Habitual Cough NO	Rheumatism NO
Appendicitis "	Disease of Liver "	Hemorrhage "	Scrofula "
Asthma "	Disease of Kidneys "	Insanity "	Spinal Diseases "
Bronchitis "	Disease of Urinary "	Intestinal or Hepatic "	Spitting or Raising "
Cancer or other "	Organs "	Cough "	Blood "
tumor "	Dropsy "	Jaundice "	Ulcer or Open Sores "
Consumption "	Fistula "	Paralysis "	Varicose Veins "
Diabetes "	Fits or Convulsions "	Pleurisy "	"
Disease of Brain	General Debility	Pneumonia	

15. Is Applicant connected in any way with the manufacture or sale of any alcoholic stimulants? If so, in what capacity? NO

16. Has Applicant ever been a pensioner, or has he an application for a pension pending or contemplated? If yes, when and for what? NO

17. Did any of the parents, grandparents, brothers or sisters of Applicant ever have Consumption or Pulmonary or Scrofulous disease? NO

18. Has Applicant ever been under treatment in any hospital or asylum or been an inmate of any alms house or any similar institution? NO

19. Has Applicant ever been seriously ill or had a serious personal injury? If so, give full particulars, including names and addresses of attending physicians. NO

20. FAMILY HISTORY—

	IF LIVING		IF DEAD	
	Age	Condition of Health	Age at Death	Cause of Death
Father	42	GOOD		
Mother	38	FAIR-EPIPLEPISY		DOES NOT KNOW
Brothers		DOES NOT LIVE NEAR MOTHER		
1/2	17	GOOD	18	PNEUMONIA
			5	ACCIDENT
Sisters				
1/1	12	"		INFANT

21. IF A FEMALE a When last pregnant? SINGLE

b Any miscarriages or difficulty in labor?

c Are uterine functions now regular? If extinct, since when?

I HEREBY DECLARE the statements given above to be full, true and correct.

CHATTANOOGA, TENN. 19 3-14-36

(Place and Date)

DOROTHY M. SAMS

(Signature of Applicant)