(PART ONE)

APPLICATION FOR INSURANCE TO

THE SOUTHERN STATES LIFE INSURANCE COMPANY

HOME OFFICE: ATLANTA, GA.

(NOTE---BLACK INK MUST BE USED IN FILLING OUT THIS APPLICATION.)

1 Applicant's full name (No abbreviation or "nick-name")	First Name / Middle Name / Last Name: Robert William Elvin	10 Kind of Policy Desired (Use Rate Book Designation)	O.L. End. 85 Dis. a
2 Exact P. O. Address Check (✓) address for future notices	City / County / State: Memphis Tenn. — St. No. (or R.F.D.) Name of St. (or Direction and Distance from P.O.) Res. 1048 N. Dunlap St — Bus. Same	11 Beneficiary's full name (Do not abbreviate)	Mrs. Edith Elvin
3 Exact former address	1173 So. Lauderdale St	12 Beneficiary's relationship	Mother
4 How long at present address?	1½ yrs. How long at former address? 1 yr	13 Applicant's Date of Birth	5 Day of Jan 1915 — 14 State of birth: Tenn.
5 Applicant's regular and all occasional or part-time occupations	Student	15 Amount of Insurance	$ 1000.00 — 16 Age LAST Birthday? 15
6 Do you expect to change your occupation or address?	No	17 Amount of premium	$ — 18 Premiums Payable: (Indicate by ✓) ✓ Annually / Semi-Ann. / Quarterly / Monthly
7 Have you ever made, or do you expect to make any aerial flight or ascension?	No	19 If short term desired, to what date?	✓ — HOME OFFICE ENDORSEMENTS: Rem 13.25
8 Life Insurance now carried in other companies	Company / Amount: None $	20 Have you ever applied for insurance without receiving a policy of the exact kind, premium and amount requested?	(Company, if any) No

What settlement have you made? Cash $ … For which Conditional Receipt No. R 37253 has been given.

My acceptance of any policy issued on this application will ratify any corrections, additions or changes made by the Company and noted in the space headed "Home Office Endorsements."

AGENT'S SIGNATURE	[illegible] Fann	Dated at	Memphis Tenn.
GEN. AGT'S SIGNATURE	[illegible] Fann	the 25 day of	July 30
SIGNED	Robert William Elvin		

(PART TWO)

NOTE: BLACK INK MUST BE USED IN FILLING OUT THIS REPORT

APPLICANT'S STATEMENTS TO THE MEDICAL EXAMINER:

1 What is your full name?	Robert William Elvin			12 Increase in weight in past two years	Natural growth, 15 lbs.	18 Do you now use or have you ever used, any habit forming drug?	No
2 Are you in any way related to the Examiner?	No	7 Have you ever been rejected for insurance, or postponed, rated up, or refused reinstatement?	No	13 Decrease in weight in past two years	— lbs.	19 Do you ever take more than one drink of intoxicants per day?	No
3 Race? (White or colored)	White	8 Have you ever been treated at any asylum or hospital?	No	14 If weight now stationary, how long has it been so?	—	20 If so, state greatest number and how often	None
4 Are you married, single, divorced, or a widower?	Single	9 Are you deformed, maimed or crippled in any way?	No	15 Have you consulted a physician or other practitioner for examination, treatment, or advice, within five years?	No	21 Have you been intoxicated within five years? (If so, how many times and when last?)	No
5 Have you within three years been in close contact with a consumptive?	No	10 Is your sight or hearing impaired to any extent?	No	16 If not, when did you last consult a physician or other practitioner?	10 yrs ago	22 If now a total abstainer, how long have you been so?	Life
6 Has any change of climate or occupation been advised or made for your health?	No	11 Have you ever applied for a pension or other disability compensation?	No	17 Give names and addresses of those consulted	Dr. [illegible] P. Jones. Memphis Tenn.		

HAVE YOU NOW OR HAVE YOU EVER HAD, OR HAVE YOU EVER BEEN TOLD BY ANY PHYSICIAN OR OTHER PRACTITIONER THAT YOU HAVE, OR HAVE HAD ANY OF THE FOLLOWING DISEASES: (ANSWER EACH QUESTION EXPLICITLY)

23 Albumin, sugar in urine, gravel, or renal colic, or any other indications of bladder or kidney disease?	No	28 Apoplexy, paralysis, diseases of the brain or nervous system, or epilepsy?	No	33 Dyspepsia or indigestion?	No	38 Cancers, tumors or ulcers of any kind?	No
24 Syphilis, gonorrhoea, stricture, or any disease of the genital or urinary organs?	No	29 Headaches—severe, protracted or frequent?	No	34 Appendicitis?	No	39 Inflammatory rheumatism?	No
25 Chronic or persistent cough, hoarseness, or disease of the throat?	No	30 Discharge from the ear, or any other chronic discharges?	No	35 Are you ruptured?	No	40 Malarial, typhoid or other fevers?	No
26 Spitting or coughing of blood, pleurisy, pneumonia, or any other chest or lung trouble?	No	31 High blood pressure, fainting, palpitation, or any indication of heart disease?	No	36 If so, do you constantly wear a truss, properly fitted?	—	41 Have you had any illness, disease or injury, not previously mentioned?	yes
27 Asthma, or shortness of breath?	No	32 Gall stones, or any disease of the liver or gall bladder?	No	37 Hemorrhoids, fistula or other diseases of the rectum?	No	42 Are you now in good health?	yes

QUESTIONS TO BE ASKED IF APPLICANT IS A FEMALE OVER 14 YEARS OF AGE.

43 If married, is your husband in good health?		46 How many children have you borne?		49 Are you now pregnant?		52-A Name of husband or father	
44 For what amount is your husband's life insured?		47 Date of last labor?		50 Have you passed the climacteric?		52-B Name of family physician	
45 Date of marriage?		48 Have you ever had an abortion or miscarriage or difficult labor?		51 Have you ever had any disease of women not mentioned heretofore?		52-C Address of family physician	

REMARKS: GIVE HERE PARTICULARS, INCLUDING DATES, DURATION, SEVERITY, RESULT AND REMAINING EFFECTS IF ANY, OF EACH DISEASE YOU HAVE HAD MENTIONED ABOVE.

[illegible]

IMMEDIATE FAMILY HISTORY	AGE (IF LIVING)	CONDITION OF HEALTH (If not good, state why) (IF LIVING)	AGE AT DEATH (IF DEAD)	CAUSE OF DEATH (BE EXPLICIT)	HOW LONG ILL	YEAR OF DEATH	PREVIOUS HEALTH
FATHER	40	Good					
MOTHER	39	Good					
BROTHERS							
SISTERS 1							
	19	Good					

I expressly waive, on behalf of myself and any other person who shall have or claim any interest in any policy issued on this application, all provisions of law forbidding any physician or other person who has attended or examined me, or who may hereafter do so, from disclosing any knowledge or information gained thereby, and hereby give my consent that such knowledge or information be furnished to this Company on request. I hereby agree that all the answers and statements made to the Company's Medical Examiner, together with those contained in my application, are true and complete, and that they are offered to The Southern States Life Insurance Company as a part of the consideration for and as the basis of the contract with said Company under any policy issued on my application, and that no other statements, representations or information made or given by or to the person soliciting or taking my application for insurance, or to any other person, shall be binding on said Company unless the same be reduced to writing and made a part of said application. And I further agree that any policy issued thereon shall not take effect unless and until the first premium shall have been actually paid to the Company and the policy delivered to me during my lifetime and continued good health, except that, when the premium has been paid in advance to an authorized Agent of the Company, and a conditional receipt on the Company's authorized form has been given by such Agent, the liability of the Company shall be as stated in such conditional receipt, and that I will accept and pay for said policy if same be issued as applied for. I agree that no person, whether agent of the Company or otherwise, who may deliver to me a policy, is authorized to determine whether I am then in good health, nor does the Company by such delivery of said policy to me determine that question, but such delivery and the taking effect of said policy is subject to the existence of my continued good health, which by receiving the said policy I represent to have been unchanged.

Signed by the person examined, in my presence:	Dated at	I certify that the foregoing questions were read to me and that my answers are correctly recorded by the medical examiner:
[illegible] M.D. (Examiner's Signature)	Memphis Tenn. (Town) the 25 day of July 1930 (Date)	Robert William Elvin (Applicant's Signature)