

1003

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STANDARD CERTIFICATE OF DEATH		Arizona State Board of Health	
1. PLACE OF DEATH		BUREAU OF VITAL STATISTICS STATE FILE NO. _____	
COUNTY <u>Graham</u>	STATE <u>ARIZONA</u>	REGISTERED NO. _____	
TOWNSHIP _____	OR VILLAGE _____	OR _____	
CITY <u>Pima</u>	NO. _____	ST. _____	WARD _____
(IF DEATH OCCURRED IN HOSPITAL OR INSTITUTION, GIVE ITS NAME INSTEAD OF STREET AND NUMBER)			
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.	
2. FULL NAME <u>BEALS, John S.</u>		NOW LONG IN STATE WHEN DEATH OCCURRED? _____ YRS. _____ MOS. _____ DS.	
(A) RESIDENCE: NO. _____ ST. _____ WARD _____		(IF NON-RESIDENT GIVE CITY OR TOWN AND STATE)	
PERSONAL AND STATISTICAL PARTICULARS			
3. SEX <u>M</u>	4. COLOR OR RACE <u>American</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (WRITE THE WORD) <u>Married</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____			
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____			
7. AGE	YEARS	MONTHS	DAYS
<u>59</u>			
IF LESS THAN 1 DAY, _____ HRS. OR _____ MIN.			
OCCUPATION	8. TRADE, PROFESSION, OR PARTICULAR KIND OF WORK DONE, AS SPINNER, SAWYER, BOOKKEEPER, ETC.		
	9. INDUSTRY OR BUSINESS IN WHICH WORK WAS DONE, AS SILK MILL, SAW MILL, BANK, ETC.		
	10. DATE DECEASED LAST WORKED AT THIS OCCUPATION (MONTH AND YEAR) _____		
11. TOTAL TIME (YEARS) SPENT IN THIS OCCUPATION _____			
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTY) _____			
FATHER	13. NAME _____		
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTY) _____		
MOTHER	15. MAIDEN NAME _____		
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTY) _____		
17. INFORMANT (ADDRESS) _____			
18. BURIAL, CREMATION, OR REMOVAL			
PLACE <u>Pima</u>		DATE _____ 19____	
19. EMBALMER FUNERAL DIRECTOR	LICENSE NO. _____	SIGNATURE _____	
	ADDRESS _____		
20. FILED _____ 19____ REGISTRAR _____			
MEDICAL CERTIFICATE OF DEATH			
21. DATE OF DEATH (MONTH, DAY, AND YEAR) <u>7-19-04</u> , 19____			
22. I HEREBY CERTIFY, THAT I ATTENDED DECEASED FROM _____, 19____, TO _____, 19____			
I LAST SAW H. _____ ALIVE ON _____, 19____; DEATH IS SAID TO HAVE OCCURRED ON THE DATE STATED ABOVE, AT _____ M.			
THE PRINCIPAL CAUSE OF DEATH AND RELATED CAUSES OF IMPORTANCE WERE AS FOLLOWS:			DATE OF ONSET
<u>Cancer (?) Bowel</u>			<u>1 mo.</u>
OTHER CONTRIBUTORY CAUSES OF IMPORTANCE: _____			
NAME OF OPERATION _____ DATE OF _____			
WHAT TEST CONFIRMED DIAGNOSIS? _____ WAS THERE AN AUTOPSY? _____			
23. IF DEATH WAS DUE TO EXTERNAL CAUSES (VIOLENCE) FILL IN ALSO THE FOLLOWING: ACCIDENT, SUICIDE, OR HOMICIDE? _____ DATE OF INJURY _____, 19____			
WHERE DID INJURY OCCUR? _____ (SPECIFY CITY OR TOWN, COUNTY AND STATE)			
SPECIFY WHETHER INJURY OCCURRED IN INDUSTRY, IN HOME, OR IN PUBLIC PLACE _____			
MANNER OF INJURY _____			
NATURE OF INJURY _____			
24. WAS DISEASE OR INJURY IN ANY WAY RELATED TO OCCUPATION OF DECEASED? _____			
IF SO, SPECIFY _____			
(SIGNED) <u>R.R. Root</u>			M. D.
(ADDRESS) _____			