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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

BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
 COUNTY Graham STATE ARIZONA
 TOWNSHIP _____ OR VILLAGE _____
 CITY Solomonville NO. _____ ST. _____ WARD _____
 (IF DEATH OCCURRED IN HOSPITAL OR INSTITUTION, GIVE ITS NAME INSTEAD OF STREET AND NUMBER)

2. FULL NAME HOORAN, C.E.
 (A) RESIDENCE: NO. _____ (USUAL PLACE OF ABODE) ST. _____ WARD _____
 HOW LONG IN U. S. IF OF FOREIGN BIRTH? YRS. _____ NOS. _____ DS. _____
 HOW LONG IN STATE WHEN DEATH OCCURRED? YRS. _____ NOS. _____ DS. _____
 (IF NON-RESIDENT GIVE CITY OR TOWN AND STATE)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE American 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) _____

7. AGE YEARS MONTHS DAYS IF LESS THAN 1 DAY, HRS. OR MIN.
75 _____

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 Solomonville DATE _____ 19 _____

19. EMBALMER } LICENSE NO. _____
 FUNERAL } SIGNATURE _____
 DIRECTOR }
 ADDRESS _____

20. FILED _____ 19 _____ REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-7-08 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

Paralysis 1 week

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) J.H.Lacy M. D.
 (ADDRESS) _____