

CERTIFICATE OF DEATH

BIRTH NO.

REGISTRAR'S NO. 18

OF DEATH AND RESIDENCE X-	1. PLACE OF DEATH A. COUNTY <u>Graham</u>		B. LENGTH OF STAY IN THIS TOWN <u>75</u> IN ARIZONA <u>77</u>		2. USUAL RESIDENCE (WHERE DECEASED LIVED, IF IN INSTITUTION; RESIDENCE BEFORE ADMISSION) A. STATE <u>Oreg</u> B. COUNTY <u>Sasham</u>		
	C. CITY OR TOWN <u>Safford</u>		<input checked="" type="checkbox"/> IN CITY LIMITS <input type="checkbox"/> OUTSIDE CITY LIMITS		C. CITY OR TOWN <u>Safford</u> <input checked="" type="checkbox"/> IN CITY LIMITS <input type="checkbox"/> OUTSIDE CITY LIMITS		
	D. FULL NAME OF HOSPITAL OR INSTITUTION				D. STREET ADDRESS (IF RURAL, GIVE LOCATION)		
CEDENT PERSONAL DATA 189 7 355	3. NAME OF DECEASED (TYPE OR PRINT) A. (FIRST) <u>JOHN</u> B. (MIDDLE) <u>OLIVER</u> C. (LAST) <u>WEST</u>			4. SEX <u>M.</u>	5. COLOR OR RACE <u>W.</u>	6A. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (SPECIFY) <u>Widowed</u>	
	6B. NAME OF SPOUSE <u>Emma West</u>		7. DATE OF BIRTH MONTH <u>April</u> DAY <u>7</u> YEAR <u>1865</u>		8. AGE (IN YEARS LAST BIRTHDAY) <u>89</u>	IF UNDER 1 YEAR MONTHS <u>195</u> DAYS	IF UNDER 24 HRS. HOURS MIN.
	9B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>N. Carolina</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		12. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, WAR OR DATES OF SERVICE) <u>No</u>
	14A. FATHER'S NAME <u>Thomas Carver West</u>		14B. BIRTHPLACE (STATE OR COUNTRY) <u>Unknown</u>		15A. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Coffey</u>		15B. BIRTHPLACE (STATE OR COUNTRY) <u>Unknown</u>
	16. INFORMANT'S SIGNATURE <u>Carol West</u>				17. DATE OF DEATH (MONTH) (DAY) (YEAR) <u>March 1-55</u>		

CAUSE OF DEATH ITEM 18)	18. CAUSE OF DEATH ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), (C). <u>Heart</u> <small>THIS DOES NOT MEAN THE MODE OF DYING, SUCH AS HEART FAILURE, ASTHENIA, ETC. IT MEANS THE DISEASE INJURY, OR COMPLICATION WHICH CAUSED DEATH. PLACE DISEASE CONTRACTED.</small>		1. DISEASE OR CONDITIONS DIRECTLY LEADING TO DEATH: A. <u>Chronic Heart Failure</u> B. <u>Arteriosclerotic Heart Disease 20 years</u> C. <u>11. OTHER SIGNIFICANT CONDITIONS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
	19A. DATE OF OPERATION <u>none</u>		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

DEATH DUE TO EXTERNAL VIOLENCE	21A. ACCIDENT (SPECIFY) SUICIDE HOMICIDE <u>none</u>		21B. PLACE OF INJURY (E.G., IN OR ABOUT HOME, FARM, FACTORY, STREET, OFFICE BLDG., ETC.)		21C. (CITY OR TOWN) (COUNTY) (STATE)	
	21D. TIME (MONTH) (DAY) (YEAR) (HOUR) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

MEDICAL OR CORONER'S CERTIFICATION	22. I HEREBY CERTIFY THAT I ATTENDED THE DECEASED FROM ALIVE ON <u>2/28</u> , 19 <u>55</u> , AND THAT DEATH OCCURRED AT <u>11/17</u> , 19 <u>55</u> , TO <u>3/1</u> , 19 <u>55</u> , THAT I LAST SAW THE DECEASED M. FROM THE CAUSES AND ON THE DATE STATED ABOVE.					
	23A. SIGNATURE <u>J. G. Fulton, M.D.</u>		23B. ADDRESS <u>Safford, Oregon</u>		23C. DATE SIGNED <u>3/5/55</u>	

FUNERAL DIRECTOR AND REGISTRAR	24A. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> REMOVAL <input type="checkbox"/>		24B. DATE <u>March 4-55</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Safford</u>		24D. LOCATION (CITY, TOWN, OR COUNTY) (STATE) <u>Safford, Oreg</u>
	25A. DATE REC'D BY LOCAL REG. <u>3/5/55</u>		25B. REGISTRAR'S SIGNATURE <u>J. M. Strickland</u>		26. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. Rawson</u> ADDRESS <u>Safford</u>	
					27. EMBALMER'S SIGNATURE <u>W. C. Rawson</u> CERT. NO. <u>116</u>	