1341

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. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

ARIZONA STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

ORIGINAL CERTIFICATE OF DEATH

State Index - - - No. 21
County Registrar's - No. 476.
Local Registrar's - No.

PLACE OF DEATH

1. County Cochise
District Tombstone
Town or City Tombstone No. Toughnut St., 2nd Ward
(If death occurred in a hospital or institution, give its NAME instead of street number)

2. FULL NAME Miriam Edna Johnson

(a) Residence. No. Toughnut St., 2nd Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 6 mos. 24 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR or RACE: White
5. SINGLE, MARRIED, WIDOWED or DIVORCED (Write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 19 1893

7. AGE: Years 29 | Months 6 | Days 24 | IF LESS than 1 day ....hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Tombstone,
(State or country) Ariz

PARENTS

10. NAME OF FATHER Samuel E. Johnson
11. BIRTHPLACE OF FATHER
(State or country) Mo (city or town)
12. MAIDEN NAME OF MOTHER Edna Taft
13. BIRTHPLACE OF MOTHER
(State or country) Vermont (city or town)

14. Informant Sam. E. Johnson
(Address)

15. Filed 8/31/23 19 H. Houston Hughart
Local Registrar.
Filed Sep 9 1923 R B Vaughn
County Registrar.

V. S. No. 1

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (month, day, and year) 19

17. I HEREBY CERTIFY, That I attended deceased from Aprio 1, 1923 19 to August 12, 1923 19, that I last saw him alive on Aug. 12, 1923 19, and that death occurred, on the date stated above, at 12:30 A m. The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. M. Randolph, M. D.
8/13/23 19 (Address) Tombstone

* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION OR REMOVAL Tombstone — DATE OF BURIAL Aug 13 '23 19

20. UNDERTAKER E.C.PORTER — ADDRESS DOUGLAS

True Copy