107

ARIZONA STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

ORIGINAL CERTIFICATE OF DEATH

State Index - - - No. 94
County Registrar's - No. 92
Local Registrar's - No. 84

PLACE OF DEATH

1. County Graham
District Safford
Town or city ..... No. ..... St., ... Ward
(If death occurred in a hospital or institution, give its NAME instead of street number)

2. FULL NAME Mary Catherine May Jenkins
(a) Residence. No. ..... St., ... Ward.
(Usual place of abode) (If nonresident, give city or town and State)
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.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (month, day and year) 9-15-1868

7. AGE 55 Years | Months 9 | Days 5 | IF LESS than 1 day 11 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or Country) West Virginia

PARENTS

10. NAME OF FATHER James M. May
11. BIRTHPLACE OF FATHER Tenkiller (city or town) (State or country)
12. MAIDEN NAME OF MOTHER Catherine Moyer
13. BIRTHPLACE OF MOTHER Tenkiller (city or town) (State or country)

14. Informant (Address) L. L. Jenkins

15. Filed Jan 8 1924 Hattie W. Schenck Local Registrar.
Filed Jan 8 1924 Dean H. Schenck County Registrar.

V. S. No. 1

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (month, day, and year) 12/20/1923

17. I HEREBY CERTIFY, That I attended deceased from 2/18 1923 to 12/20/23, 19..., that I last saw her alive on 12/17 1923 and that death occurred, on the date stated above, at 11 a.m.
The CAUSE OF DEATH* was as follows:
Chronic Enteritis
Nephritis
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? no date of
Was there an autopsy? no
What test confirmed diagnosis?
Signed J. Newton Shaw M. D.
12/20 1923 (Address) Safford

* 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 Safford
DATE OF BURIAL 12/22 1923

20. UNDERTAKER None
ADDRESS —

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