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MARGIN RESERVED FOR BINDING. 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.

ARIZONA STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS  
ORIGINAL CERTIFICATE OF DEATH

State Index - No. 126  
County Registrar's - No. 224  
Local Registrar's - No.

PLACE OF DEATH  
 1. County Hela  
 District Hela  
 Town or city \_\_\_\_\_ No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (If death occurred in a hospital or institution, give its NAME instead of street number)  
 2. FULL NAME Lucile N. Casadore  
 (a) Residence. No. \_\_\_\_\_ (Usual place of abode) St. \_\_\_\_\_ Ward \_\_\_\_\_  
 Length of residence in city or town where death occurred 3 mos. 28 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR or RACE 4/4 Indian 5. SINGLE, MARRIED, WIDOWED or DIVORCED Single  
 6a. If married, widowed, or divorced HUSBAND of \_\_\_\_\_ (or) WIFE of \_\_\_\_\_  
 6. DATE OF BIRTH (month, day and year) 2/24/21  
 7. AGE Years Months Days IF LESS than 1 day hrs. or min. 3 28  
 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) (State or Country) Hela Ariz  
 10. NAME OF FATHER Alfred Casadore  
 11. BIRTHPLACE OF FATHER Rice Ariz (city or town) (State or country)  
 12. MAIDEN NAME OF MOTHER Heard Hecker  
 13. BIRTHPLACE OF MOTHER Rice Ariz (city or town) (State or country)  
 14. Informant (Address) Mrs A Casadore  
 15. Filed 6-22-24 1924 W. J. S. J. Registrar.  
 Filed 6-22-24 1924 W. J. S. J. Registrar.  
 V. S. No. 1 \_\_\_\_\_ County Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (month, day, and year) 6/22 1924  
 17. I HEREBY CERTIFY, That I attended deceased from No medical attendance that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_ and that death occurred, on the date stated above, at \_\_\_\_\_ The CAUSE OF DEATH\* was as follows:  
Acute Colitis  
 (duration) yrs. mos. 3 ds.  
 CONTRIBUTORY (secondary) None known (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? None  
 Signed C. H. Sawyer M. D. 7/24 1924 (Address) Douglas Ariz  
 \* 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 Rice Ariz DATE OF BURIAL 6/27 1924  
 20. UNDERTAKER None ADDRESS \_\_\_\_\_