9318

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. See instructions on back of certificate.

ARIZONA STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

ORIGINAL CERTIFICATE OF DEATH

State Index - - - No. 272
County Registrar's - No.
Local Registrar's - No. 47

PLACE OF DEATH

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

2. FULL NAME Herman E. Whiting
(a) Residence. No. St Johns Ariz 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: Male
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)

7. AGE: Years 22 | Months ~~Dec~~ 2 | Days 23 | IF LESS than 1 day hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Mill operator
(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): Chihuahua Mexico

PARENTS

10. NAME OF FATHER: Charles Whiting
11. BIRTHPLACE OF FATHER: Iowa (city or town) (State or country)
12. MAIDEN NAME OF MOTHER: Verona Snow
13. BIRTHPLACE OF MOTHER: Utah (city or town) (State or country)

14. Informant: Frank M. Whiting
(Address)

15. Filed Aug 28 1924 John S. Woods Local Registrar
Filed ____ 19____ ____ County Registrar.

V. S. No 1

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (month, day, and year) Aug 27 1924

17. I HEREBY CERTIFY, That I attended deceased from ____ to ____ 19____
that I last saw him alive on ____ 19____
and that death occurred, on the date stated above, at ____ m.
The CAUSE OF DEATH* was as follows:
Fracture of Skull due to wheel at Work.
(duration) ____ yrs. ____ mos. ____ ds.

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

18. Where was disease contracted if not at place of death?
Did an operation precede death? ____ date of ____
Was there an autopsy?
What test confirmed diagnosis?
Signed L M Fallon M. D.
Aug 29 1924 (Address) Ajo

*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: Ajo Cem.
DATE OF BURIAL: 8-29-1924

20. UNDERTAKER
ADDRESS