

ARIZONA STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

State Index - - - No. 2
 County Registrar's - No. 37
 Local Registrar's - No. 51

ORIGINAL CERTIFICATE OF DEATH

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

2. FULL NAME James Emory Waite
 (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 M 4. COLOR or RACE W 5. SINGLE, MARRIED, WIDOWED or DIVORCED (Write the word) _____
 6. If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____
 6. DATE OF BIRTH (month, day and year) 1/29/25
 7. AGE Years _____ Months _____ Days 4 IF LESS than 1 day hrs. _____ or min. _____
 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business or establishment in which employed (or employer) _____ (c) Name of employer _____
 9. BIRTHPLACE (city or town) St Johns Ariz (State or Country) _____
 10. NAME OF FATHER Garrett Waite
 11. BIRTHPLACE OF FATHER St Johns (city or town) (State or country) _____
 12. MAIDEN NAME OF MOTHER Albina Aschcraft
 13. BIRTHPLACE OF MOTHER Parach (city or town) (State or country) _____
 14. Informant Garrett Waite (Address) St Johns Ariz
 15. Filed 2/5/25 1925 Walter H. Nichols Local Registrar
 Filed 3/10/25 1925 H. H. Nichols County Registrar
 V. S. No. 1

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (month, day, and year) FEB 2 1926
 17. I HEREBY CERTIFY, That I attended deceased from 1/29 1925 to 2/2 1925 that I last saw her alive on _____ 19____ and that death occurred, on the date stated above, at 3 P m. The CAUSE OF DEATH* was as follows:
Coronary thrombosis of
valves
 (duration) _____ yrs. _____ mos. 4 ds.
 CONTRIBUTORY (secondary) not sure of cause (duration) _____ yrs. _____ mos. _____ ds.
 18. When 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? _____
 Signed J. O. Baudier M. D. St Johns Ariz (Address)
 * State the Disease Causing Death, or the death 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 _____ DATE OF BURIAL 2/3/26 19____
 20. UNDERTAKER _____ ADDRESS St Johns

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.