1227

ARIZONA STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

ORIGINAL CERTIFICATE OF DEATH

State Index - - - - - No. 137
County Registrar's - - No.
Local Registrar's - - - No. 19.

PLACE OF DEATH

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

2. FULL NAME Thula Roberta Reed
(a) Residence. No. Graham, Ariz. St., Ward. (If non-resident, give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 1 yrs. 4 mos. 15 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 Monte Reed
6. DATE OF BIRTH (month, day and year) Nov - 11 - 1924
7. AGE Years 1 Months 4 Days 15 IF LESS than 1 day X hrs. or X 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) Graham, Ariz
(State or country)

PARENTS

10. NAME OF FATHER Robert Reed
11. BIRTHPLACE OF FATHER Tenn. (city or town)
(State or country)
12. MAIDEN NAME OF MOTHER Maude Lester
13. BIRTHPLACE OF MOTHER Tenn. (city or town)
(State or country)

14. Informant Robert Reed
(Address) Graham, Ariz.

15. Filed April 8, 1926 J. N. Stratton M.B. Local Registrar.
Filed ....., 19 ..... County Registrar.

V. S. No. 1

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (month, day, and year) Mar 25 1926

17. I HEREBY CERTIFY, That I attended deceased from Mar 1, 1926 to Mar. 25, 1926, that I last saw her alive on Mar 25, 1926 and that death occurred, on the date stated above, at 10 15 P m.
The CAUSE OF DEATH* was as follows:

Acute gastro enteritis

(duration) ..... yrs. ..... mos. 25 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ..... yrs. ..... mos. 25 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) D Scott Schenck M. D.
Mar. 26 1926 (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 Graham Cemetary
DATE OF BURIAL 9/26 19/26
20. UNDERTAKER None
ADDRESS —

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.