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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.

PLACE OF DEATH		ARIZONA STATE BOARD OF HEALTH	
1. County <u>Cochise</u>	BUREAU OF VITAL STATISTICS	State Index - - No. <u>27</u>	
District <u>Benson</u>	ORIGINAL CERTIFICATE OF DEATH	County Registrar's No. _____	
Town or City <u>Benson</u>	No. _____	Local Registrar's - No. <u>14</u>	
2. FULL NAME <u>Margaret Jane Sabie</u>		St. _____	Ward _____
(a) Residence. No. _____		(If nonresident, give city or town and State)	
(Usual place of abode)		Length of residence in city or town where death occurred <u>26</u> yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.	
PERSONAL AND STATISTICAL PARTICULARS			
3. SEX <u>Female</u>	4. COLOR or RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED or DIVORCED <u>Widow</u> (write the word)	
5a. If married, widowed, or divorced HUSBAND of <u>Ambrose Sabie</u> (or) WIFE of _____			
6. DATE OF BIRTH (month, day and year)			
7. AGE	Years	Months	Days
<u>73</u>	<u>10</u>	<u>23</u>	IF LESS than 1 day.....hrs. or.....min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Housewife</u> (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) <u>St. Francis County, Arkansas</u>			
10. NAME OF FATHER <u>John F. Sabie</u>			
11. BIRTHPLACE OF FATHER (city or town) (State or country) <u>Don't know</u>			
12. MAIDEN NAME OF MOTHER <u>Agnes W. Lehman</u>			
13. BIRTHPLACE OF MOTHER (city or town) (State or country) <u>Don't know</u>			
14. Informant (Address) <u>John H. Sabie</u>			
15. Filed <u>9/6</u> , 19 <u>26</u> <u>J. N. Morrison</u> Registrar			
V. S. No. 1			
MEDICAL CERTIFICATE OF DEATH			
16. DATE OF DEATH (month, day, and year) <u>9/15</u> 19 <u>26</u>			
17. I HEREBY CERTIFY, That I attended deceased from <u>June 1</u> , 19 <u>25</u> to <u>Sept. 15</u> , 19 <u>26</u> , that I last saw her alive on <u>Sept. 15</u> , 19 <u>26</u> , and that death occurred, on the date stated above, at <u>9 A. M.</u> The CAUSE OF DEATH* was as follows: <u>Cerebral Apoplexy</u>			
(duration) <u>1</u> yrs. <u>5</u> mos. ds.			
CONTRIBUTORY (Secondary) (duration) _____ yrs. mos. ds.			
18. Where was disease contracted if not at place of death? _____			
Did an operation precede death? <u>No</u> Date of _____			
Was there an autopsy? <u>No</u>			
What test confirmed diagnosis? <u>Clinical</u>			
(Signed) <u>J. N. Morrison</u> , M. D. 19 (Address) <u>Benson</u>			
* 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 <u>St. David</u>		DATE OF BURIAL <u>Sept. 16</u> 19 <u>26</u>	
20. UNDERTAKER		ADDRESS	