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BUREAU OF VITAL STATISTICS **ARIZONA STATE BOARD OF HEALTH** STANDARD CERTIFICATE OF DEATH

State File No. 243

Registered No. 288

1. PLACE OF DEATH

County Maricopa State

District or Township or Village or

City Phoenix No. Booker T. Washington Hospital Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number).

2. FULL NAME Horrace E. Clark

(a) Residence. No. Not Known St., Ward.

(Usual place of abode) (If non-resident, 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	4. COLOR or RACE	5. SINGLE, MARRIED, WIDOWED or DIVORCED. (Write the word)
M	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Not Known

7. AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
About 35			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(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) Missouri

PARENTS

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (city or town)
(State or country) Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (city or town)
(State or country) Not Known

14. Informant Hospital Records
(Address)

15. Filed 3-18, 1927. [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 20th, 1927
Month Day Year

17. I HEREBY CERTIFY, That I attended deceased from
, 19 to , 19 ,
that I last saw him alive on Never , 19 ,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Septicemia (Septicemia)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) The injured hand

(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? Yes
What test confirmed diagnosis? Autopsy
(Signed) [signature], M. D.
(Address) Phoenix

* 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	DATE OF BURIAL
Forest Lawn Cemetery	3/18/27

20. UNDERTAKER ACTON-MANSFIELD CO. ADDRESS 334 W. MONROE ST.

N. B.—WRITE PLAINLY, WITH UNFADING INK. MARGIN RESERVED FOR BINDING. 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.