

MARGIN RESERVED FOR BINDING. 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.

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

1. PLACE OF DEATH  
 County Maricopa State \_\_\_\_\_  
 District or Township \_\_\_\_\_ or Village \_\_\_\_\_  
 City Phoenix No. 4 mi S.E. Wilson district St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (If death occurred in a hospital or institution, give its NAME instead of street and number).  
 State File No. 175  
 Registered No. 720

2. FULL NAME Bulah Richardson Smith  
 (a) Residence, No. \_\_\_\_\_ (Usual place of abode) St. \_\_\_\_\_ Ward \_\_\_\_\_  
 Length of residence in city or town where death occurred yrs. 7 mos. 13 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. Married  
 (Write the word)

5a. If married, widowed, or divorced  
 HUSBAND of \_\_\_\_\_  
 (or) WIFE of Shelton Smith

6. DATE OF BIRTH (month, day and year) Oct 26, 1908

7. AGE Years 19 Months 6 Days 15  
 IF LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ or \_\_\_\_\_ min.

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work At Home  
 (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) Okla

10. NAME OF FATHER H.C. Richardson

11. BIRTHPLACE OF FATHER \_\_\_\_\_ (State or country) Ark. (city or town)

12. MAIDEN NAME OF MOTHER Laura Rogers

13. BIRTHPLACE OF MOTHER \_\_\_\_\_ (State or country) Mo. (city or town)

14. Informant Shelton Smith  
 (Address) \_\_\_\_\_

15. Filed 5-23-28 \_\_\_\_\_ Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5-11-28  
 Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

17. I HEREBY CERTIFY, That I attended deceased from 3/1-1928 to 5/11-1928 that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred, on the date stated above, at 10:49 m. The CAUSE OF DEATH\* was as follows:  
Pulmonary Tuberculosis  
Chronic  
 (duration) 7 yrs. 5 mos. \_\_\_\_\_ ds.

CONTRIBUTORY (Secondary) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. Where was disease contracted if not at place of death? not known  
 Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_  
 Was there an autopsy? \_\_\_\_\_  
 What test confirmed diagnosis? Physical Exam  
 (Signed) \_\_\_\_\_ (Address) Phoenix M. D.  
 \* 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 Greenwood DATE OF BURIAL 5-12-28

20. UNDERTAKER A. L. MOORE & SONS ADDRESS \_\_\_\_\_