

MAINTAINED 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.

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

1. PLACE OF DEATH Phoenix State File No. 941
 County Maricopa State Arizona Registered No. 718
 District or Township _____ or Village _____
 City Phoenix (If death occurred in a hospital or institution, give its NAME instead of street and number).
 2. FULL NAME Eva May Evans
 (a) Residence, No. _____ 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 F 4. COLOR or RACE wh 5. SINGLE, MARRIED, WIDOWED or DIVORCED W
 (Write the word)
 6a. If married, widowed, or divorced
 HUSBAND of _____
 (or) WIFE of Acorn Evans
 6. DATE OF BIRTH (month, day and year) _____
 7. AGE Years _____ Months _____ Days _____ 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) Arizona
 (State or country)
 10. NAME OF FATHER Acorn Evans
 11. BIRTHPLACE OF FATHER _____ (city or town)
 (State or country) Ark
 12. MAIDEN NAME OF MOTHER Miss Paul
 13. BIRTHPLACE OF MOTHER _____ (city or town)
 (State or country) Ark
 14. Informant _____
 (Address) _____
 15. Filed 5-23-28 [Signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5/20/28
 Month _____ Day _____ Year _____
 17. I HEREBY CERTIFY That I attended deceased from May 4, 1928 to May 20, 1928 that I last saw h. _____ alive on _____ and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:
Anhydremia
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (Secondary) _____ (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? _____
 What test confirmed diagnosis? _____
 (Signed) [Signature], M. D.
 19. PLACE OF BURIAL, CREMATION OR REMOVE Frank Larson DATE OF BURIAL 5/21/28
 20. UNDERTAKER [Signature] ADDRESS [Signature]

* 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.)