9608

BUREAU OF VITAL STATISTICS

ARIZONA STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 233

Registered No. 97

1. PLACE OF DEATH

County Maricopa State Arizona

District or Township _____ or Village _____

City Phoenix No. St. Joseph's Hospital St., _____ or Ward

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

2. FULL NAME ~~Bertha Lay Cashon~~

(a) Residence. No. _____ (Usual place of abode) St., _____ Ward. _____

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.

(If non-resident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR or RACE	5. SINGLE, MARRIED, WIDOWED or DIVORCED. (Write the word)
Female	White	Married

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

6. DATE OF BIRTH (month, day and year) Aug. 22, 1906

7. AGE Years	Months	Days	IF LESS than 1 day ____ hrs. or ____ min.
20	4	12	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(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) Ark.

PARENTS

10. NAME OF FATHER J. J. Bones

11. BIRTHPLACE OF FATHER _____ (city or town) (State or country) Tenn.

12. MAIDEN NAME OF MOTHER Tennie Bones

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

14. Informant W. H. Cashon

(Address)

15. Filed _____, 19 _____ Registrar.

3 22869

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 6 (Month) 6 (Day) 19 29 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 4, 1929 to Jan 6, 1929 that I last saw h[illegible] alive on Jan 6, 1929 and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

Gunshot wound
Abdomen, lower bowel
Stomach & spleen

(duration) _____ yrs. _____ mos. 2 ds.

CONTRIBUTORY (Secondary) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death? _____

Did an operation precede death? Yes Date of Jan 4, 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Bleeding up and down

(Signed) [illegible] 19 _____ (Address) _____, 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 Forest Lawn — DATE OF BURIAL 1/9/29

20. UNDERTAKER A. H. LeSellun — ADDRESS 617 N. Central

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.

MARGIN RESERVED FOR BINDING