9762

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

State File No. 385

Registered No. 122

1. PLACE OF DEATH

County Maricopa State Arizona

District or Township _____ or Village _____ or

City P P hoenix No. Good Samaritan Hospital St., _____ Ward

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

2. FULL NAME James Alexander Pettijohn

(a) Residence. No. Gila Bend Ariz. 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)
Male	White	single

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

6. DATE OF BIRTH (month, day and year) Feb. 27/1927

7. AGE Years	Months	Days	IF LESS than 1 day ____ hrs. or ____ min.
1	10	22	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ---6-----

(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) Texas

PARENTS

10. NAME OF FATHER B. E. Pettijohn

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

12. MAIDEN NAME OF MOTHER Saulter

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

14. Informant B. E. Pettijohn (Address)

15. Filed _____, 19 _____ Registrar.

3 22669

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 22/ 1929 19__ (Month Day Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19__ to _____, 19__, that I last saw him alive on Jan 21, 1929, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

Cerebro spinal meningitis

_____ (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? No Date of _____

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Harry J. Field, M. D.

Jan 22 1929 (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 Forest Lawn

DATE OF BURIAL Jan. 23-29

20. UNDERTAKER A. L. MOORE & SONS

ADDRESS