

2304

ARIZONA STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

State Index - - - - No. 146
County Registrar's - - No. ~~155~~ 9
Local Registrar's - - - No. ~~155~~ 9

ORIGINAL CERTIFICATE OF DEATH

PLACE OF DEATH
1. County Graham
District Safford
Town or City Safford

2. FULL NAME Peter J. C. Jacobson
(a) Residence No. Safford Ariz St., Ariz Ward. Ariz
(If non-resident, give city or town and State)
Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S. if of foreign birth? 71 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR or RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED or DIVORCED. (Write the word) <u>Widower</u>
5a. If married, widowed or divorced HUSBAND of <u>Lena Jacobson</u> (or) WIFE of		
6. DATE OF BIRTH (month, day and year) <u>April 26/85</u>		
7. AGE Years <u>82</u> Months <u>9</u> Days <u>21</u>	IF LESS than 1 day _____ hrs. or _____ min.	
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Merchant</u> (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) <u>Denmark</u>		
10. NAME OF FATHER <u>Fredrick Jacobson</u>		
11. BIRTHPLACE OF FATHER (city or town) (State or country) <u>Denmark</u>		
12. MAIDEN NAME OF MOTHER <u>Elizabeth Peterson</u>		
13. BIRTHPLACE OF MOTHER (city or town) (State or country) <u>Denmark</u>		
14. Informant (Address) <u>Fredrick Jacobson Safford</u>		
15. Filed <u>March 4, 1929</u> <u>J. N. Stratton</u> Local Registrar. H.B.G. Filed _____, 19____ County Registrar.		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (month, day, and year) Feb 17 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb 15th, 1929 to Feb 17th, 1929, that I last saw him alive on Feb 15th, 1929 and that death occurred, on the date stated above, at 1:20 P. m. The CAUSE OF DEATH* was as follows:
Myo carditis
Chronic Interstitial
nephritis
(duration) _____ yrs. _____ mos. _____ ds.

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

18. When 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? H.W.S. quibb, M.D. (Signed) _____ (Address) Safford Ariz

* 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 <u>H.C. Rawson Safford</u>	DATE OF BURIAL <u>Feb. 21 1929</u>
20. UNDERTAKER <u>H.C. Rawson</u>	ADDRESS <u>Safford</u>

THIS IS A PERMANENT RECORD. Every item of information should be carefully checked for accuracy. Physicians should state CAUSE OF DEATH in full. OCCUPATION is very important. See instructions on certificate.