829

MARGIN RESERVED 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

State File No. 821

Local Registrar's No. 112

1. PLACE OF DEATH

County _____ State _____

District or Township _____ or Village _____

City _____ No. _____ St., _____ Ward

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

2. FULL NAME Leo Berlin Haverty

(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: Male

4. COLOR or RACE: White

5. SINGLE, MARRIED, WIDOWED or DIVORCED. (Write the word): Married

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

6. DATE OF BIRTH (month, day and year) July 25, 1905

7. AGE: Years 23 Months 9 Days IF LESS than 1 day ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED

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

(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) New Mexico

PARENTS

10. NAME OF FATHER Thomas T. Haverty

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

12. MAIDEN NAME OF MOTHER Lenora Simpson

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

14. Informant Robert Haverty (Address)

15. Filed Apr 12, 1929 L. E. Irving Registrar.

3 25974

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 11 (Day) 1929 (Year)

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

Mine Accident

_____ (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) W. C. Mitchell Coroner, M.D. 19 (Address)

* 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: Bisbee Ariz

DATE OF BURIAL: Apr 13-29

20. UNDERTAKER: J. Ivy Miles

ADDRESS: Miami