9223

BUREAU OF VITAL STATISTICS

ARIZONA STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 457

Registered No. 220

1. PLACE OF DEATH

County Pinal State

District or Township or Village

City Florence No. St., Ward

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

2. FULL NAME Alice Graham

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

6. If married, widowed, or divorced: ~~HUSBAND of~~ (or) ~~WIFE of~~ Robert Graham

7. DATE OF BIRTH (month, day and year) 1874

AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
55	2	1	

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) Cowley county Kansas

10. NAME OF FATHER John Graham

11. BIRTHPLACE OF FATHER Kentucky

(State or country) Pennsylvania (city or town)

12. MAIDEN NAME OF MOTHER Shepard

13. BIRTHPLACE OF MOTHER Kentucky

(State or country) (city or town)

14. Informant Rob Graham

(Address) Florence Arizona

15. Filed 5/31/ 1, 1929 B. Lewis M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF ~~BIRTH~~ death April Month 10 Day 1929 Year

17. I HEREBY CERTIFY, That I attended deceased from 26, 1929 to April 10, 1929 that I last saw her alive on April 10, 1929, and that death occurred, on the date stated above, at 9:00 p.m. The CAUSE OF DEATH* was as follows:

Cardiac Dilitation

(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) [illegible] M.D.

May 31 1929 (Address) Florence 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	DATE OF BURIAL
Florence Cem	Apr. 12 1929
20. UNDERTAKER	**ADDRESS**
D. C. Martin	Florence