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BUREAU OF VITAL STATISTICS (Corrected Copy) ARIZONA STATE BOARD OF HEALTH STANDARD CERTIFICATE OF DEATH

State File No. 34

Registered No. 56

1. PLACE OF DEATH

County Cochise State Arizona

District or Township _____ or Village _____

City Benson No. _____ St., _____ Ward

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

2. FULL NAME Alberto Trivicis

(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. 5 ds. How long in U. S. if of foreign birth? _____ yrs. _____ mos. _____ ds.

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR or RACE: Mexican

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

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Don't Know

6. DATE OF BIRTH (month, day and year): _____

7. AGE: Years 22 Months 2 Days 2 IF LESS than 1 day _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Cowboy

(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): Don't Know

PARENTS

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (city or town) (State or country): ~~Don't Know~~

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (city or town) (State or country): Don't Know

14. Informant: Ignacio Araiza

(Address): Benson Ariz.

15. Filed Aug. 13, 1929. R. O. Kirkwood M.D. Registrar.

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MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 13 (Day), 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 8, 1929 to Aug 13, 1929, that I last saw him alive on Aug. 13, 1929 and that death occurred, on the date stated above, at 6.25 p.m. The CAUSE OF DEATH* was as follows:

Catarrhal Intestinal Acute

(duration) _____ yrs. _____ mos. 5 ds.

CONTRIBUTORY (Secondary): Acute alcoholism

(duration) _____ yrs. _____ mos. 5 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) J. N. Morrison, M. D.

Aug. 13, 1929 (Address) Benson 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: Benson-Ariz.

DATE OF BURIAL: Aug. 13, 1929

20. UNDERTAKER: Greinds-

ADDRESS: Benson Ariz.