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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. 258

1. PLACE OF DEATH

County Maricopa State Arizona Local Registrar's No. 1180

District or Township _____ or Village _____ or

City Phoenix No. 1442 E. Madison St., _____ Ward

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

2. FULL NAME Mary Slade

(a) Residence, No. 1442 E. Madison St. 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 14 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	Negro	Single

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

6. DATE OF BIRTH (month, day and year) July 6, 1915

7. AGE	Years	Months	Days	IF LESS than 1 day ___ hrs. or ___ min.
	14	1	20	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School Girl

(b) General nature of industry, business or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Phoenix

(State or country) Arizona

PARENTS

10. NAME OF FATHER Abber Slade

11. BIRTHPLACE OF FATHER _____ (city or town)

(State or country) Texas

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER _____ (city or town)

(State or country) Unknown

14. Informant Sermancie Sewell

(Address) 7th Ave. & Mongolia St.

15. Filed Sept. 4, 1929 [signature] Registrar.

3 25974

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 26, (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:

Blows on head with a hoe in hands of Samuel Butler.

_____ (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) [signature], Coroner, M.D.

August 27th 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 Sept. 5-1929

20. UNDERTAKER W. E. Willis

ADDRESS 401 W. Jefferson