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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. 276

1. PLACE OF DEATH

County Maricopa State Arizona Local Registrar's No. 14

District or Township ____ or Village Wickenburg or

City ____ No. At home St. ____ Ward

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

2. FULL NAME Elizabeth Jane Witherlay

(a) Residence, No. Wickenburg St. Tegner Ward ____

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 30 about yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR or RACE: White

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

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

6. DATE OF BIRTH (month, day and year): 1855-3/18

7. AGE: Years 74 Months 8 Days 11 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: City Clerk & Postmistress

(b) General nature of industry, business or establishment in which employed (or employer): City & Office

(c) Name of employer: —

9. BIRTHPLACE (city or town): Cascade (State or country): Wisconsin

PARENTS

10. NAME OF FATHER: John J. Ausbourne

11. BIRTHPLACE OF FATHER: Greenport (city or town) (State or country): Kentucky

12. MAIDEN NAME OF MOTHER: Elizabeth Ausbourne

13. BIRTHPLACE OF MOTHER: Rutland (city or town) (State or country): Vermont

14. Informant: Olive H. Hoch - Sister

(Address): Basalt Colorado

15. Filed 11/24 1929 J. A. Copeland Registrar.

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MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov - 24 - 1929 (Month Day Year)

17. I HEREBY CERTIFY, That I attended deceased from She died no Physician, 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:

Probably Grippe

(duration) ____ yrs. ____ mos. 4 ds.

CONTRIBUTORY (Secondary): Age

(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of X

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J. A. Copeland, M. D.

19__ (Address) Wickenburg

* 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: Wickenburg

DATE OF BURIAL: 11/25

20. UNDERTAKER: Wickenburg Funeral Home

ADDRESS: Wickenburg