2493

BUREAU OF VITAL STATISTICS

ARIZONA STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 225

Registered No. 1596

1. PLACE OF DEATH

County Maricopa State

District or Township or Village

City Phoenix No. Park Ave. Mt. Lower Tempe Rd. St., or Ward

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

2. FULL NAME Bessie May Cox

(a) Residence, No. (Usual place of abode) St., Ward.

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. (If non-resident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

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 Walter Cox

6. DATE OF BIRTH (month, day and year) May 15-1890

7. AGE Years 39 Months 7 Days 0 IF LESS than 1 day hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House-wife

(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) Oklahoma

PARENTS

10. NAME OF FATHER J. M. Farris

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

12. MAIDEN NAME OF MOTHER Annie Salz

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

14. Informant (Address)

15. Filed Dec. 18, 1929 J. W. Goodman Registrar.

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MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 15 - 1929 (Month Day Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15, 1929 to Dec 15, 1929, that I last saw h alive on , 19 , and that death occurred, on the date stated above, at 4 A m. The CAUSE OF DEATH* was as follows:

Uremic Coma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Parturition

(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? Clinical

(Signed) Cox S. Hughes, 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 Twin Butte

DATE OF BURIAL Dec 18-1929

20. UNDERTAKER H. M. Maus

ADDRESS 830 N. 1st Ave

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.

MARGIN RESERVED FOR BINDING