590

BUREAU OF VITAL STATISTICS

ARIZONA STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 4728a

Registered No. 8

1. PLACE OF DEATH

County Pinal State Arizona

District or Township ____ or Village ____ or

City Florence No. ____ St., ____ Ward

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

2. FULL NAME Charley Whitlow

(a) Residence, No. San Carlos 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 ____ yrs. ____ mos. ____ 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: White

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

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Dorcas E Whitlow

6. DATE OF BIRTH (month, day and year) June 10th 1871

7. AGE: Years 58 | Months 7 | Days 0 | IF LESS than 1 day ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

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

(c) Name of employer ____

9. BIRTHPLACE (city or town) San Bernardino (State or country) Calif.

PARENTS

10. NAME OF FATHER Charles Whitlow

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

12. MAIDEN NAME OF MOTHER Sarah Jane MacKee

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

14. Informant Mary E Bailey

(Address) 1844 E Sixth St Tucson Arizona

15. Filed 3-10, 1930 D. O. Martin Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF ~~BIRTH~~ Death Jan. (Month) 26 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 3 1930 to Jan 26, 1930, that I last saw him alive on Jan 26, 1930 and that death occurred, on the date stated above, at 8 P m. The CAUSE OF DEATH* was as follows:

Pulmonary Abscess

(duration) ____ yrs. 6 mos. 24 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

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

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

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? ____

(Signed) B B Moeur, 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: Florence Cemetery — DATE OF BURIAL: Jan. 28" 30 —

20. UNDERTAKER: D. O. Martin. ADDRESS: Florence