

2476

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.

STANDARD CERTIFICATE OF DEATH ARIZONA STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County YAVAPAI State ARIZONA District or Township U S VETERANS' HOSPITAL City WHIPPLE, ARIZONA
No. _____ (If death occurred in a hospital or institution, give its NAME instead of street and number).
St. _____ Ward TNE TEN

State File No. 539
Local Registrar's No. 74-2

2. FULL NAME Cornelius Valentine KILKELLY, XC-1,396,310
(a) Residence, No. Newport, Rhode Island 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. 11 mos. 10 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS				
3. SEX MALE	4. COLOR or RACE WHITE	5. SINGLE, MARRIED, WIDOWED or DIVORCED. (Write the word) SINGLE		
5a. If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____				
6. DATE OF BIRTH (month, day and year) <u>Feb. 14, 1889</u>				
7. AGE	Years <u>42</u>	Months <u>1</u>	Days <u>25</u>	IF LESS than 1 day or _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Clerk, Telegraph</u> (b) General nature of industry, business or establishment in which employed (or employer) (c) Name of employer				
9. BIRTHPLACE (city or town) <u>New Paultz, New York</u> (State or country)				
10. NAME OF FATHER <u>Edward Kilkelly (dec)</u>				
11. BIRTHPLACE OF FATHER <u>Galway, Ireland</u> (State or country) (city or town)				
12. MAIDEN NAME OF MOTHER <u>Johanna Donahue</u>				
13. BIRTHPLACE OF MOTHER <u>County Cork, Ireland</u> (State or country) (city or town)				
14. Informant <u>C. C. BENEDICT, Act. Clinical Dir. U.S.V.H., WHIPPLE, ARIZONA</u>				
15. Filed <u>4/9/30</u> , 19 <u>30</u>				

MEDICAL CERTIFICATE OF DEATH			
16. DATE OF DEATH	<u>April 8,</u>	19 <u>30</u>	
	Month	Day	Year
17. I HEREBY CERTIFY, That I attended deceased from <u>April 27,</u> 19 <u>29</u> to <u>April 8,</u> 19 <u>30</u> , that I last saw him alive on <u>April 8,</u> 19 <u>30</u> , and that death occurred, on the date stated above, at <u>10:25 A.M.</u> The CAUSE OF DEATH* was as follows: <u>TUBERCULOSIS OF MENINGES</u> Approximate (duration) _____ yrs. _____ mos. <u>15</u> ds. CONTRIBUTORY Tuberculosis of the Lungs (Secondary) Approximate (duration) <u>3</u> yrs. _____ mos. _____ ds.			
18. Where was disease contracted if not at place of death? <u>unknown</u>			
Did an operation precede death? <u>NO</u> Date of _____			
Was there an autopsy? <u>Yes</u>			
What test confirmed diagnosis? <u>Autopsy</u> (Signed) <u>G. D. KELLEY, M.D., in Charge, D. April 9, 1930.</u> (Address) <u>Whipple, Ariz.</u>			
* 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		DATE OF BURIAL	
<u>Newport Rhode Island</u>		<u>4/9/30</u>	
REGISTRAR		ADDRESS	
<u>Arthur J. Southwick</u>		<u>West Guffey, Prescott, Ariz.</u>	