

2091

MARGIN RESERVED FOR BINDING
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 Maricopa State Arizona State File No. 339
 District or Township _____ or Village _____ Local Registrar's No. 2469
 City Phoenix No. Good Samaritan Hospital St. _____ Ward _____
 (If death occurred in a hospital or institution, give its NAME instead of street and number).

2. FULL NAME Barbara Ruth Boston
 (a) Residence, No. 1021 E. Brill 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. 9 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. Single
 (Write the word)

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

6. DATE OF BIRTH (month, day and year) Aug. 16, 1929

7. AGE Years Months Days IF LESS than 1 day or min.
9 8

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work None
 (b) General nature of industry, business or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (city or town) Phoenix, Arizona
 (State or country)

10. NAME OF FATHER Robert F. Boston

11. BIRTHPLACE OF FATHER Not known
 (State or country) (city or town)

12. MAIDEN NAME OF MOTHER Thelma Olver

13. BIRTHPLACE OF MOTHER Not known
 (State or country) (city or town)

14. Informant Robert F. Boston
 (Address) 1021 E. Brill

15. Filed May 28, 1930 J. W. Fedman
 Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 24, 1930
 Month Day Year

17. I HEREBY CERTIFY, That I attended deceased from May 13, 1930 to May 24, 1930
 that I last saw her alive on May 24, 1930
 and that death occurred, on the date stated above, at 5 P. M.
 The CAUSE OF DEATH* was as follows:
Enterocolitis
Cycolitis

CONTRIBUTORY (Secondary) Cycolitis
 (duration) yrs. 1 mos. 15 ds.
 (duration) yrs. mos. 12 ds.

18. Where was disease contracted if not at place of death?
 Did an operation precede death? No Date of _____
 Was there an autopsy? No
 What test confirmed diagnosis? Clinical course
 (Signed) [Signature] 19 _____ (Address) _____ M. D.

* 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 May 26, 1930

20. UNDERTAKER A. L. Moore & Sons ADDRESS Phoenix, Ariz

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