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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.

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

1. PLACE OF DEATH  
County Mohave State Arizona  
District or Township Kingman or Village  
City Chloride No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number).

2. FULL NAME Luzinda Kittrell  
(a) Residence. No. \_\_\_\_\_ 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 14 yrs. 0 mos. 0 ds. How long in U. S. if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

PERSONAL AND STATISTICAL PARTICULARS				
3. SEX <u>Female</u>	4. COLOR or RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED or DIVORCED. (Write the word) <u>Widowed</u>		
5a. If married, widowed, or divorced HUSBAND of _____ (or) WIFE of <u>William Kittrell</u>				
6. DATE OF BIRTH (month, day and year) <u>June 10th 1869</u>				
7. AGE <u>62</u>	Years	Months <u>8</u>	Days <u>24</u>	IF LESS than 1 day _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>House wife</u> (b) General nature of industry, business or establishment in which employed (or employer) <u>none</u> (c) Name of employer <u>none</u>				
9. BIRTHPLACE (city or town) <u>on farm</u> (State or country) <u>Monroe county, Tennessee</u>				
10. NAME OF FATHER <u>John Trew</u>				
11. BIRTHPLACE OF FATHER <u>unknown</u> (State or country) <u>Virginia</u> (city or town)				
12. MAIDEN NAME OF MOTHER <u>Martha Winters</u>				
13. BIRTHPLACE OF MOTHER <u>unknown</u> (State or country) <u>Ireland</u> (city or town)				

MEDICAL CERTIFICATE OF DEATH
16. DATE OF DEATH (month, day, and year) <u>3-5</u> 19 <u>32</u>
17. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____, that I last saw h_____ alive on _____ 19____, and that death occurred, on the date stated above, at <u>9</u> <u>0</u> m. The CAUSE OF DEATH* was as follows: <u>intra cranial hemorrhage</u>
(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (Secondary) _____ (duration) _____ yrs. _____ mos. _____ ds.
18. Where was disease contracted If not at place of death? _____ Did an operation precede death? <u>no</u> Date of _____ Was there an autopsy? <u>no</u> What test confirmed diagnosis? <u>ex officio coroner</u> (Signed) <u>Coroner J. L. Weiner</u> <u>March 5th 1932</u> (Address) <u>Chloride, 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.)

14. Informant Mrs Irene Smith  
(Address) Chloride, Arizona  
15. Filed March 8 1932 H. H. Brazier Registrar.  
19. PLACE OF BURIAL, CREMATION OR REMOVAL Chloride, Arizona DATE OF BURIAL Mar 8-1932  
20. UNDERTAKER Edwin Marto ADDRESS Kingman Ariz