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ARIZONA STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

ORIGINAL CERTIFICATE OF DEATH

State Index - - - - - No.
County Registrar's - - No.
Local Registrar's - - - No. 5

PLACE OF DEATH

1. County YUMA

District COLO. RIVER AGENCY

Town or City

No. COLO. RIVER AGENCY HOSPITAL St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street number).

2. FULL NAME Stillborn infant Willson

(a) Residence. No. Colo. River Agency 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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR or RACE 4/4 Mohave Indian

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) July 6 1934

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

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work -
(b) General nature of industry, business or establishment in which employed (or employer) -
(c) Name of employer -

9. BIRTHPLACE (city or town) C.R.A.
(State or country) Ariz

PARENTS

10. NAME OF FATHER Johnnie Willson ?

11. BIRTHPLACE OF FATHER C.R.A. (city or town)
(State or country) Ariz.

12. MAIDEN NAME OF MOTHER Helen Cleaveland

13. BIRTHPLACE OF MOTHER C.R.A. (city or town)
(State or country) Ariz.

14. Informant Colo. River Agency
(Address) Ariz.

15. Filed July 9 1934 Abbie E. Collins Local Registrar.

Filed 19 County Registrar.

V. S. No. 1

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (month, day, and year) July 6 1934

17. I HEREBY CERTIFY, That I attended deceased from July 6, 1934 to July 6, 1934 that I last saw a ~~alive on~~ 19 and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Stillborn- Mother's Kahn pos
Wasserman Neg. Infant Macerated.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Maternal syphilis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? unknown
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? tests

(Signed) Anna I. Neale, M. D.
July 7 1934 (Address) C. R. A.

*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 C.R.A.

DATE OF BURIAL July 7 19

20. UNDERTAKER Local Indians

ADDRESS

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.