4316

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.

Arizona State Board of Health

BUREAU OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

STATE FILE NO. 116

1. PLACE OF DEATH

COUNTY Graham STATE ARIZONA REGISTERED NO. 17

TOWNSHIP OR VILLAGE OR

CITY Central NO. ST. WARD

(IF DEATH OCCURRED IN HOSPITAL OR INSTITUTION, GIVE ITS NAME INSTEAD OF STREET AND NUMBER)

LENGTH OF RESIDENCE IN CITY OR TOWN WHERE DEATH OCCURRED 34 YRS. MOS. DS. HOW LONG IN U. S. IF OF FOREIGN BIRTH? YRS. MOS. DS.

2. FULL NAME Myron E. Allred HOW LONG IN STATE WHERE DEATH OCCURRED? 34 YRS. MOS. DS.

(A) RESIDENCE: NO. Central ST. WARD

(USUAL PLACE OF ABODE) (IF NON-RESIDENT GIVE CITY OR TOWN AND STATE)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, ~~WIDOWED, OR DIVORCED~~ (WRITE THE WORD)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Elizabeth O Allred

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 8-1890

7. AGE: YEARS 44 MONTHS 2 DAYS 18 IF LESS THAN 1 DAY, HRS. OR MIN.

OCCUPATION

8. TRADE, PROFESSION, OR PARTICULAR KIND OF WORK DONE, AS SPINNER, SAWYER, BOOKKEEPER, ETC. Laborer

9. INDUSTRY OR BUSINESS IN WHICH WORK WAS DONE, AS SILK MILL, SAW MILL, BANK, ETC.

10. DATE DECEASED LAST WORKED AT THIS OCCUPATION (MONTH AND YEAR)

11. TOTAL TIME (YEARS) SPENT IN THIS OCCUPATION

12. BIRTHPLACE (CITY OR TOWN) Fairview (STATE OR COUNTY) Idaho

FATHER

13. NAME Edsil Myron Allred

14. BIRTHPLACE (CITY OR TOWN) Springville (STATE OR COUNTY) Utah

MOTHER

15. MAIDEN NAME Alice Chambers

16. BIRTHPLACE (CITY OR TOWN) Bibbage (STATE OR COUNTY) England

17. INFORMANT Elizabeth O Allred (ADDRESS) Central, Ariz.

18. BURIAL, CREMATION, OR REMOVAL PLACE Central DATE 2/15/, 1935

19. EMBALMER { LICENSE NO. SIGNATURE

FUNERAL DIRECTOR N. C. Rawson

ADDRESS Safford, Graham

20. FILED Mar 9, 1935 J. M. Stratton REGISTRAR

By [illegible]

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-13-, 1935

22. I HEREBY CERTIFY, THAT I ATTENDED DECEASED FROM 2-7-, 1935, TO 2-13-, 1935

I LAST SAW HIM ALIVE ON 2-13, 1935; DEATH IS SAID TO HAVE OCCURRED ON THE DATE STATED ABOVE, AT 4 P M.

THE PRINCIPAL CAUSE OF DEATH AND RELATED CAUSES OF IMPORTANCE WERE AS FOLLOWS:

	DATE OF ONSET
Static Pneumonia	
due to Dilated Heart	2-6-35

OTHER CONTRIBUTORY CAUSES OF IMPORTANCE:

Leaky Heart

NAME OF OPERATION DATE OF

WHAT TEST CONFIRMED DIAGNOSIS? WAS THERE AN AUTOPSY?

23. IF DEATH WAS DUE TO EXTERNAL CAUSES (VIOLENCE) FILL IN ALSO THE FOLLOWING:

ACCIDENT, SUICIDE, OR HOMICIDE? DATE OF INJURY, 19

WHERE DID INJURY OCCUR? (SPECIFY CITY OR TOWN, COUNTY AND STATE)

SPECIFY WHETHER INJURY OCCURRED IN INDUSTRY, IN HOME, OR IN PUBLIC PLACE

MANNER OF INJURY

NATURE OF INJURY

24. WAS DISEASE OR INJURY IN ANY WAY RELATED TO OCCUPATION OF DECEASED?

IF SO, SPECIFY

(SIGNED) W. B. Platt, M. D.

(ADDRESS) M.D.

10M—10-8-34—REP-GAZ PRINTERY—FORM 3

BACK OF CERTIFICATE TO BE USED FOR ANY ADDITIONAL INFORMATION