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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.

STANDARD CERTIFICATE OF DEATH **Arizona State Board of Health** **81**

BUREAU OF VITAL STATISTICS STATE FILE NO. _____

1. PLACE OF DEATH

COUNTY Dila STATE ARIZONA REGISTERED NO. 95

TOWNSHIP _____ OR VILLAGE _____

CITY Miami 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 YRS. 2 MOS. _____ DS. HOW LONG IN U. S. IF OF FOREIGN BIRTH? YRS. _____ MOS. _____ DS.

2. FULL NAME Alfonso C. Hernandez HOW LONG IN STATE WHEN DEATH OCCURRED? YRS. 1 MOS. 17 DS.

(A) RESIDENCE; NO. E. E. Davis Highway ST. _____ WARD _____

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>Sp. Mex.</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED, (WRITE THE WORD) <u>Single</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 20 1936

7. AGE	YEARS	MONTHS	DAYS	IF LESS THAN 1 DAY, _____ HRS. OR _____ MIN.
		<u>1</u>	<u>19</u>	

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

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) (STATE OR COUNTY) Miami Fla.

MOTHER

13. NAME Robert Hernandez

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTY) Havana

15. MAIDEN NAME Elena Castro

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTY) Spain

FATHER

17. INFORMANT Robert Hernandez

(ADDRESS) 640 Davis Highway

18. BURIAL, CREMATION, OR REMOVAL Burial

PLACE Home DATE Dec 16 1936

19. EMBALMER } LICENSE NO. 2274

FUNERAL DIRECTOR } SIGNATURE [Signature]

ADDRESS Miami, Fla.

20. FILED Dec 16 1936 E. M. Cron REGISTRAR

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 7 1936

22. I HEREBY CERTIFY, THAT I ATTENDED DECEASED FROM Dec. 8th 1936 TO Dec. 9th 1936

I LAST SAW HIM ALIVE ON Dec. 8- 1936; DEATH IS SAID TO HAVE OCCURRED ON THE DATE STATED ABOVE, AT 4:30 A.M.

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

Bronchial Pneumonia 8th 1936

OTHER CONTRIBUTORY CAUSES OF IMPORTANCE: Influenza

NAME OF OPERATION None DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS? _____ WAS THERE AN AUTOPSY? No

23. IF DEATH WAS DUE TO EXTERNAL CAUSES (VIOLENCE) FILL IN ALSO THE FOLLOWING: ACCIDENT, SUICIDE, OR HOMICIDE? _____ DATE OF INJURY _____

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 None

NATURE OF INJURY _____

24. WAS DISEASE OR INJURY IN ANY WAY RELATED TO OCCUPATION OF DECEASED? No

IF SO, SPECIFY _____

(SIGNED) Eyrol M. Cron M. D.

(ADDRESS) Miami, Arizona