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② **Arizona State Board of Health**
BUREAU OF VITAL STATISTICS

STATE FILE NO. _____

STANDARD CERTIFICATE OF DEATH

STATE _____ ARIZONA _____ REGISTERED NO. 73 _____ OR

1. PLACE OF DEATH _____
COUNTY _Gila_ OR VILLAGE _____ ST., _____ WARD
TOWNSHIP _Claypool_ NO. _____ (IF DEATH OCCURRED IN HOSPITAL OR INSTITUTION, GIVE ITS NAME INSTEAD OF STREET AND NUMBER)
CITY _____

LENGTH OF RESIDENCE _____ (IF DEATH OCCURRED _18_ YRS. _____ MOS. _____ DS. HOW LONG IN U. S. IF OF FOREIGN BIRTH? _18_ YRS. _____ MOS. _____ DS.
IN CITY OR TOWN WHERE DEATH OCCURRED _18_ YRS. _____ MOS. _____ DS. HOW LONG IN STATE WHEN DEATH OCCURRED? _____ YRS. _____ MOS. _____ DS.

2. FULL NAME _Francis C. Reyes_
(A) RESIDENCE: NO. _300 Groves Canon_ ST., _____ WARD. (IF NONRESIDENT GIVE CITY OR TOWN AND STATE)
(USUAL PLACE OF ABODE)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (WRITE THE WORD
Female	_Mex_	_Married_

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF _Ramon Reyes_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _Nov 13 1915_

7. AGE	YEARS	MONTHS	DAYS	IF LESS THAN 1 DAY. ___ HRS. OR ___ MIN.
	_21_	_7_	_19_	

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

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) _Aguas Calientes_ (STATE OR COUNTRY) _Mexico_

13. NAME _Jose M. Castaneda_

14. BIRTHPLACE (CITY OR TOWN) _Old Mexico_ (STATE OR COUNTRY)

15. MAIDEN NAME _Satura Montez_

16. BIRTHPLACE (CITY OR TOWN) _Old Mexico_ (STATE OR COUNTRY)

17. INFORMANT _Ramon Reyes_ (ADDRESS) _300 Grover Canon_

18. BURIAL, CREMATION, OR REMOVAL DATE _7/3_, 19_37_
PLACE _Pinal Cem._

19. EMBALMER LICENSE NO. _200_ _W.H. McLellan_
FUNERAL DIRECTOR SIGNATURE _Miles Mortuary_
ADDRESS _Miami Ariz_ _R. M. Oron_ REGISTRAR

20. FILED _July 6_, 19_37_

FORM 3—100% RAG

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) _7/2_.19_37_

22. I HEREBY CERTIFY, THAT I ATTENDED DECEASED FROM
July 2, 19_37_ TO _July 2_, 19_37_, DEATH IS SAID
I LAST SAW HIM ALIVE ON _____, AT _8.30 P_. M.
TO HAVE OCCURRED ON THE DATE STATED ABOVE, AT
THE PRINCIPAL CAUSE OF DEATH AND RELATED CAUSES OF IMPORTANCE WERE AS FOLLOWS:

	DATE OF ONSET
Pulmonary hemorrhage	_7/2/37_

OTHER CONTRIBUTORY CAUSES OF IMPORTANCE:
Pulmonary tuberculosis _?_

NAME OF OPERATION _None_ 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? _No_
IF SO, SPECIFY (SIGNED) _John K. Walsh_ M. D.
(ADDRESS) _Miami Ariz_

BACK OF CERTIFICATE TO BE USED FOR ANY ADDITIONAL INFORMATION