

4147

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Arizona State Board of Health

BUREAU OF VITAL STATISTICS

STATE FILE NO. _____

STANDARD CERTIFICATE OF DEATH

1. PLACE OF DEATH
 COUNTY Gila STATE ARIZONA REGISTERED NO. _____
 TOWNSHIP _____ OR VILLAGE _____
 CITY Miami NO. _____ (IF DEATH OCCURRED IN HOSPITAL OR INSTITUTION, GIVE ITS NAME INSTEAD OF STREET AND NUMBER) ST. _____ WARD _____
 LENGTH OF RESIDENCE (IF DEATH OCCURRED IN HOSPITAL OR INSTITUTION, GIVE ITS NAME INSTEAD OF STREET AND NUMBER) YRS. _____ MOS. _____ DS. _____ HOW LONG IN STATE IF FOREIGN BIRTH? YRS. _____ MOS. _____ DS. _____
 IN CITY OR TOWN WHERE DEATH OCCURRED _____ HOW LONG IN STATE WHEN DEATH OCCURRED? YRS. _____ MOS. _____ DS. _____
 2. FULL NAME Belea Quesada ST. _____ WARD _____ (IF NON-RESIDENT GIVE CITY OR TOWN AND STATE)
 (A) RESIDENCE NO. 108 Red Springs Canyon (USUAL PLACE OF ABODE)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Mexican 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) May 6, 1931
 7. AGE YEARS MONTHS DAYS IF LESS THAN 1 DAY, HRS. OR MIN.
6 4 22
 8. TRADE, PROFESSION, OR PARTICULAR KIND OF WORK DONE, AS SPINNER, SAWYER, BOOKKEEPER, ETC. Child at Home
 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) Casa Blia California

FATHER 13. NAME Lebrado Quesada

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTY) Golisco Mexico

MOTHER 15. MAIDEN NAME Constancia Jaurizal

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTY) Golisco Mexico

17. INFORMANT (ADDRESS) Lebrado Quesada

18. BURIAL, CREMATION, OR REMOVAL PLACE Pinal Cemetery DATE 9/29/37 19. _____

19. EMBALMER LICENSE NO. 200A SIGNATURE W. H. McLellan
 FUNERAL DIRECTOR Miles Mortuary
 ADDRESS Miami, Arizona

20. FILED Sept 29, 1937 REGISTRAR Richard D. Gray

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 28, 1937
 22. I HEREBY CERTIFY THAT I ATTENDED DECEASED FROM Sept 18-37 TO Sept 28-37
 I LAST SAW HER ALIVE ON Sept 28, 1937; DEATH IS SAID TO HAVE OCCURRED ON THE DATE STATED ABOVE, AT 7:05 P. M.
 THE PRINCIPAL CAUSE OF DEATH AND RELATED CAUSES OF IMPORTANCE WERE AS FOLLOWS:
Diphtheria DATE OF ONSET Sept 18-1937
Endocarditis
Respiratory paralysis
 OTHER CONTRIBUTORY CAUSES OF IMPORTANCE: _____
 NAME OF OPERATION None DATE OF _____
 WHAT TEST Laboratory report WAS THERE AN AUTOPSY? No
 CONFIRMED DIAGNOSIS _____
 23. IF DEATH WAS DUE TO EXTERNAL CAUSES (VIOLENCE) FILL IN ALSO THE FOLLOWING: ACCIDENT, SUICIDE, OR HOMICIDE? No 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 None
 NATURE OF INJURY _____
 24. WAS DISEASE OR INJURY IN ANY WAY RELATED TO OCCUPATION OF DECEASED? No
 IF SO, SPECIFY _____ M. D.
 (SIGNED) W. H. McLellan
 (ADDRESS) Miami, Arizona

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.