

1939

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

1. PLACE OF DEATH
STANDARD CERTIFICATE OF DEATH
COUNTY Mohave STATE ARIZONA STATE FILE NO. 285
TOWNSHIP _____ OR VILLAGE Littlefield REGISTERED NO. _____
CITY _____ NO. _____ OR _____ WARD _____

LENGTH OF RESIDENCE (IF DEATH OCCURRED IN HOSPITAL OR INSTITUTION, GIVE ITS NAME INSTEAD OF STREET AND NUMBER) ST. _____ WARD _____
IN CITY OR TOWN WHERE DEATH OCCURRED _____ YRS. _____ MOS. _____ DS. HOW LONG IN U.S. IF OF FOREIGN BIRTH? _____ YRS. _____ MOS. _____ DS.
2. FULL NAME Sarahanna McKnight HOW LONG IN STATE WHEN DEATH OCCURRED? _____ YRS. _____ MOS. _____ DS.
(A) RESIDENCE: NO. _____ ST. _____ WARD Littlefield
(IF NON-RESIDENT GIVE CITY OR TOWN AND STATE)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED, (WRITE THE WORD) Widow

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____
7. AGE YEARS MONTHS DAYS IF LESS THAN 1 DAY, _____ HRS. OR _____ MIN. 82 11 9

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) (STATE OR COUNTY) Provo Utah

MOTHER: 13. NAME _____
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTY) _____
15. MAIDEN NAME Polle Don Zabinski
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTY) _____

17. INFORMANT (ADDRESS) _____
18. BURIAL, CREMATION, OR REMOVAL PLACE Beaver Dam DATE Mar 17, 1939
19. EMBALMER (LICENSE NO. _____) SIGNATURE _____
FUNERAL DIRECTOR (ADDRESS) _____

20. FILED Mar 30, 1939 Joseph DeLeon REGISTRAR

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) _____ 1939
22. I HEREBY CERTIFY, THAT I ATTENDED DECEASED FROM _____, 1939, TO March 15, 1939
LAST SAW HER ALIVE ON March 15, 1939; DEATH IS SAID TO HAVE OCCURRED ON THE DATE STATED ABOVE, AT 11:00 A.M.
THE PRINCIPAL CAUSE OF DEATH AND RELATED CAUSES OF IMPORTANCE WERE AS FOLLOWS:
Carcinoma of sigmoid colon with abdominal metastases DATE OF ONSET 2 yrs
3 mos
OTHER CONTRIBUTORY CAUSES OF IMPORTANCE: Terminal hypostatic pneumonia 3 days
NAME OF OPERATION _____ DATE OF _____
WHAT TEST CONFIRMED DIAGNOSIS? None AS 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 _____
NATURE OF INJURY _____
24. WAS DISEASE OR INJURY IN ANY WAY RELATED TO OCCUPATION OF DECEASED? No
IF SO, SPECIFY (SIGNED) Joseph DeLeon M. D. (ADDRESS) 1201 George St.