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.

MARGIN RESERVED FOR BINDING

STANDARD CERTIFICATE OF DEATH

Arizona State Board of Health

BUREAU OF VITAL STATISTICS

State File No. 80

Registered No. 45

1. PLACE OF DEATH

County: Graham

Township:

City: ..... State: ARIZONA

(If death occurred in a hospital or institution, give its NAME instead of street and number) St. ..... or ..... Ward

Length of residence in city or town where death occurred: 4 yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME: Sarah M. Horlacher

(a) Residence: Ft Thomas — How long in State when death occurred? 14 yrs. ..... mos. ..... ds.

(Usual place of abode) (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

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Sam. Horlacher

6. DATE OF BIRTH (month, day, and year): Nov. 12-1850

7. AGE: Years 88 | Months 5 | Days 6 | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: None

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 Country): Canada

FATHER

13. NAME: Lawrence Harrison

14. BIRTHPLACE (city or town) (State or Country): Unknown

MOTHER

15. MAIDEN NAME: Unknown

16. BIRTHPLACE (city or town) (State or Country): Unknown

17. INFORMANT (Address): Sam Horlacher, Ft. Thomas.

18. BURIAL, CREMATION, OR REMOVAL

Place: Ft Thomas Date: Apr. 19, 1935

19. EMBALMER: License No. ..... Signature: .....

FUNERAL DIRECTOR: W. C. Ramsey

Address: Safford

20. Filed: May 7, 1935 — Mrs. Jeff Stratton, Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, and year): Apr. 18, 1935

22. I HEREBY CERTIFY, That I attended deceased from April 10, 1939, to 4-18, 1939

I last saw him alive on 4-17, 1939; death is said to have occurred on the date stated above, at 3 P.M.

The principal cause of death and related causes of importance were as follows:

	Date of Onset
Chronic myocarditis	

Other contributory causes of importance:

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? 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

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) M. E. Lull, M. D.

(Address) Safford Arizona

5M 12-16-38 A.P. Form 3 100% Rag

Back of Certificate to be used for any Additional Information