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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

BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH  
 County Yuma State ARIZONA State File No. \_\_\_\_\_  
 Township \_\_\_\_\_ or Village \_\_\_\_\_ Registered No. 135  
 City Yuma No. Yuma General Hospital Ward \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number)  
 Length of residence 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 Mary Elizabeth Briggs How long in State when death occurred 7 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (a) Residence: Dome, Arizona (Usual place of abode) \_\_\_\_\_ (If a resident give city or town and state)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word) <u>Married</u>				
5a. If married, widowed, or divorced <u>HUSBAND</u> of <u>Charles D. Briggs</u> (or) WIFE of _____						
6. DATE OF BIRTH (month, day, and year) <u>January 15, 1865</u>						
7. AGE <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">Years <u>74</u></td> <td style="width: 33%;">Months <u>7</u></td> <td style="width: 33%;">Days <u>4</u></td> <td style="width: 15%;">If LESS than 1 day, _____ hrs. or _____ min.</td> </tr> </table>			Years <u>74</u>	Months <u>7</u>	Days <u>4</u>	If LESS than 1 day, _____ hrs. or _____ min.
Years <u>74</u>	Months <u>7</u>	Days <u>4</u>	If LESS than 1 day, _____ hrs. or _____ min.			
OCCUPATION	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. <u>Housewife</u>					
10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation				
12. BIRTHPLACE (city or town) <u>Maquan</u> (State or Country) <u>Ill.</u>						
FATHER	13. NAME <u>Nelson D. Combs</u>					
	14. BIRTHPLACE (city or town) <u>Unknown</u> (State or Country) <u>Ill.</u>					
MOTHER	15. MAIDEN NAME <u>Polly Ann Auderkirk</u>					
	16. BIRTHPLACE (city or town) <u>Maquan</u> (State or Country) <u>Ill.</u>					
17. INFORMANT <u>Judson C. Briggs</u> (Address) <u>Dome, Arizona</u>						
18. BURIAL, CREMATION, OR REMOVAL Place <u>Yuma Cemetery</u> Date <u>8/21/39</u> , 19 <u>39</u>						
19. EMBALMER { License No. <u>0134</u> Signature <u>[Signature]</u> FUNERAL DIRECTOR <u>[Signature]</u> Address <u>[Address]</u>						
20. Filed <u>Aug 27</u> , 19 <u>39</u> <u>Mary W. [Signature]</u> Registrar (Signed) <u>[Signature]</u> M. D. (Address) <u>Yuma Arizona</u>						

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, and year) August 19, 1939

22. I HEREBY CERTIFY, That I attended deceased from 8/18/39, 1939, to 8/19/39, 1939.  
 I last saw her alive on 8/18/39, 1939; death is said to have occurred on the date stated above, at 12:10 pm.  
 The principal cause of death and related causes of importance were as follows:  
Suppurative pneumonia  
Cardiac failure  
Cerebral thrombosis  
 Date of Onset (?)  
[Signature]

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ 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) [Signature] M. D. (Address) [Address]