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E---On R.
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

San Carlos Agency
STANDARD CERTIFICATE OF DEATH Registered No. **83**

1. PLACE OF DEATH:
County Gila State Arizona
Township On reservation with medical care or Village San Carlos or
City _____ No. San Carlos Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number) Ward _____
Length of residence in city or town where death occurred life yrs. _____ mos. _____ days. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ days.

2. FULL NAME Reed, Dolly Mae
Residence: No. San Carlos, Arizona St., _____ Ward _____ (If not resident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS				
3. SEX <u>Female</u>	4. COLOR OR RACE <u>4/4 Apache</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>		
5a. If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____				
6. DATE OF BIRTH (month, day, and year) <u>July 21, 1939</u>				
7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or mins.
	-	4	8	
OCCUPATION	8. Trade, profession, or particular kind of work done as spinner, sawyer, bookkeeper, etc. <u>None</u>			
	9. Industry or business in which work was done, as silk mill, sawmill, bank, etc. <u>-</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 and State or country): <u>San Carlos, Arizona</u>				
FATHER	13. NAME: <u>Reed, Robert Perry</u>			
	14. BIRTHPLACE (city or town and State or country): <u>San Carlos, Arizona</u>			
MOTHER	15. MAIDEN NAME: <u>Reede, Anna</u>			
	16. BIRTHPLACE (city or town and State or country): <u>San Carlos, Arizona</u>			
17. INFORMANT (name and address): <u>Hospital, San Carlos, Arizona</u>				
18. BURIAL, CREMATION, OR REMOVAL: Place <u>San Carlos, Ariz.</u> Date <u>Dec. 1st</u> , 193 <u>9</u>				
19. UNDERTAKER (name and address): <u>Family, San Carlos, Arizona</u>				
20. FILED <u>Dec. 1st</u> , 193 <u>9</u> <u>Robert H. Cunningham</u> Registrar.				

MEDICAL CERTIFICATE OF DEATH	
21. DATE OF DEATH (month, day, and year) <u>November 30th, 1939</u>	
22. I HEREBY CERTIFY, That I attended deceased from <u>Nov. 27th</u> , 193 <u>9</u> , to <u>Nov. 30th</u> , 193 <u>9</u> I last saw her alive on <u>Nov. 30th</u> , 193 <u>9</u> death is said to have occurred on the date stated above, at <u>5:20 p.m.</u>	
The principal cause of death and related causes of importance were as follows: <u>Diarrhea, fermentative.</u> Date of onset <u>11-27-39</u>	
Other contributory causes of importance:	
Name of operation _____	Date of _____
What test confirmed diagnosis? <u>Clinical</u>	Was there an autopsy? <u>No</u>
23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 193 <u>9</u> 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) <u>Robert H. Cunningham M.D.</u> (Address) <u>San Carlos, Arizona</u>	