2 1 4 8

ARIZONA STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

59

STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No........
Registrar's No. **93**

1. Place of Death: (a) County....Gila.... (b) City or Town....Globe.... (c) Location....County Hospital....
(If outside city limits write RURAL) (St. & No. (or) Name of Institution)

(d) Length of Stay: In Hospital or Institution....I Day....; In Community....I Day....; In Arizona....17 Days....
(Specify whether years, months or days)

2. Usual Residence of Deceased: (a) State....New Mexico....; (b) County............; (c) City or Town....Albuquerque....
(If outside city limits write RURAL)

(d) Street No............; (e) If foreign born, in U. S. A............yrs.

3. (a) FULL NAME....Julia Miller.... (b) If veteran name war........ (c) Social Security No. **None**
(If NONE write the word)

4. Sex	5. Color or Race	6. (a) Single, married, widowed or divorced
Female	Gypsey	Married

6. (b) Name of husband or wife	6. (c) Age of husband
Joe Miller	or wife, if alive............yrs.

7. Birthdate of deceased....1908....
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
32			hrs............ min............

9. Birthplace....Chicago.... Ill..
(City, town or county) (State or Country)

10. Usual Occupation ....

11. Industry or Business............

Father 12. Name....Steve Yenes....
13. Birthplace....Spain....
(City, town or county) (State or Country)

Mother 14. Maiden Name....Mary Demito....
15. Birthplace....Spain....
(City, town or county) (State or Country)

16. (a) Informant's own signature....Joe Miller....
(b) Address....Albuquerque N. M.,....

17. (a) Burial, Cremation or Removal....Burial....
(b) Place....Pinal Cem. (c) Date....Sept 20 19 40

18. (a) Embalmer's Signature....Fred E. Jones....
(b) Funeral Director....Fred E. Jones....
(c) Address....Globe Arizona....

19. (a) ....Sept 20 1940....
(Date received, local Registrar)
(b) ....Julia Warelee....
(Registrar's Signature)

5M 100% Rag 5-17-40

MEDICAL CERTIFICATION

20. DATE OF DEATH (Month, day and year)....Sept 17 19 40
TIME (Hour and minute)....9 p....M.

21. I hereby certify that I attended the deceased from....Sept 17 1940....
....19.... to....Sept 17, 19 40;
that I last saw her alive on....Sept 17.... 19 40;
and that death occurred on the date and hour stated above.

Immediate cause of death........

Septicemia

Due to....Abortion....

Due to........

	DURATION
Septicemia	4 days
Abortion	4 days

Other conditions....3 months pregnant....
(Include pregnancy within 3 months of death)

Major findings of operations....Named placenta....Kane can aborted in Winslow Sept 16, 1940

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide or homicide (specify)........
(b) Date of occurrence........
(c) Where did injury occur?........
(City or Town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?........
(Specify type of place)
While at work?........ (e) Means of injury........

23. Signature....Nelson D. Boynton....M.D.
Address....Miami.... Date signed....Sept 19 1940