

912

308

STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

ARIZONA STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL STATISTICS

State File No. _____

Registrar's No. 777

1. Place of Death: (a) County Maricopa (b) City or Town Phoenix (c) Location St Joseph Hosp
(If outside city limits also write RURAL) (St. & No. (or) Name of Institution)

(d) Length of Stay: In Hospital or Institution 3 Days; In Community 3 Days; in Arizona 53 Yrs
(Specify whether years, months or days)

2. Usual Residence of Deceased: (a) State Ariz; (b) County Maricopa; (c) City or Town Safford
(If outside city limits also write RURAL)

(d) Street No. Box 625 Safford Arizona (e) Citizen of foreign country (yes or No) _____

3. (a) FULL NAME Anna Irene John (b) If Veteran name war _____ (c) If Yes, which country _____ (d) Social Security No. none
(If NONE write the word)

4. Sex <u>Female</u>	5. Color or Race <u>White</u>	6. (a) Single, married, widowed or divorced <u>Married</u>
6. (b) Name of husband or wife <u>Chas</u>	6. (c) Age of husband or wife, if alive. <u>55</u> yrs.	
7. Birthdate of deceased Month: <u>Oct</u> Day: <u>12</u> Year: <u>1888</u>		
8. AGE: Years <u>53</u>	Months <u>7</u>	Days <u>17</u>
If less than one day hrs. _____ min. _____		
9. Birthplace <u>Central Ariz</u> (City, town or county) (State or Country)		
10. Usual Occupation <u>Housewife</u>		
11. Industry or Business <u>Home</u>		
Father	12. Name <u>Joseph C Cluff</u>	
	13. Birthplace <u>Unknown Utah</u> (City, town or county) (State or Country)	
Mother	14. Maiden Name <u>Elizabeth Moody</u>	
	15. Birthplace <u>Unknown Utah</u> (City, town or county) (State or Country)	

16. (a) Informant's own signature Chas P John
(b) Address Safford Ariz Box 625

17. (a) Burial, Cremation or Removal Removal
(b) Place Safford Ariz (c) Date 5 31 42 19

18. (a) Embalmer's Signature Toupin
(b) Funeral Director Mortensen & King
(c) Address 1020 W. Wash

19. (a) MAY 29 1942
(Date received local Registrar)

(b) [Signature]
(Registrar's Signature)

20M 100% Reg 9-19-41

MEDICAL CERTIFICATION

20. DATE OF DEATH (Month, day and year) May 29, 1942, 19____; TIME (Hour and minute) 4:30 A. M.

21. I hereby certify that I attended the deceased from 5-26, 1942 to 5-29, 1942; that I last saw her alive on 5-27, 1942; and that death occurred on the date and hour stated above.

Immediate cause of death CARDIAC FAILURE

Due to HYPERTENSION

Due to CHR. NEPHRITIS

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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 [Signature] M. D. Address Johnson Clinic Date signed 5-29-42

DURATION <u>30 YRS</u>
YEARS
PHYSICIAN
Underline the cause to which death should be charged statistically