

STATE 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. \_\_\_\_\_  
 (St. & No. (or) Name of Institution)

Place of Death: (a) County Gila (b) City or Town San Carlos (c) Location Not in hospital  
 (If outside city limits also write RURAL)

Place of Stay: In Hospital or Institution \_\_\_\_\_; In Community 11 mo., 22 da.; In Arizona life  
 (Specify whether years, months or days)

Residence of Deceased: (a) State Arizona; (b) County Gila; (c) City or Town San Carlos  
 (If outside city limits also write RURAL)

Age at No. \_\_\_\_\_; (e) Citizen of foreign country (Yes or No) \_\_\_\_\_  
 (If Yes, which country) \_\_\_\_\_

Full Name Barbara Jean Reede (b) If Veteran name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

5 Race  
 White  Indian  Negro  Oriental

6. (a) Single, married, widowed or divorced  
Single

6. (c) Age of husband or wife, if alive \_\_\_\_\_ yrs.

Date of deceased Dec. 14, 1942  
 (Month) (Day) (Year)

Years	Months	Days	hrs.	min.
<u>11</u>	<u>22</u>			

If less than one day

Place San Carlos Ariz.  
 (City, town or county) (State or Country)

1 Occupation None

2 Industry or Business \_\_\_\_\_

Name Herbert Reede  
 Birthplace San Carlos Ariz.  
 (City, town or county) (State or Country)

Spouse Name Edna Crockett  
 Birthplace San Carlos Ariz.  
 (City, town or county) (State or Country)

Informant's own signature Anna Reede  
 Address San Carlos, Arizona

Burial, Cremation or Removal Burial  
 Place San Carlos (c) Date Dec. 6, 19 44

Embalmer's Signature \_\_\_\_\_

Funeral Director None

Address \_\_\_\_\_

May 14, 1944  
 (Date received Local Registrar)

[Signature]  
 (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH (Month, day and year) Dec. 5, 19 43.  
 TIME (Hour and minute) 2:00 P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia lobular

Due to Exposure

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings:  
 Of operations None

Of autopsy None

DURATION  
11-25 to  
12-5

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 [Signature] M. D.  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_