

2891

STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

ARIZONA STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL STATISTICS

State File No. 446

Registrar's No. 39

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

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

2. Usual Residence of Deceased: (a) State Arizona; (b) County Pinal; (c) City or Town Casa Grande Rural
(If outside city limits also write RURAL)

(d) Street No. _____; (e) Citizen of foreign country (yes or No) _____
If Yes, which country _____ (f) Social Security No. _____

3. (a) FULL NAME Glora Faye Fautner (b) If Veteran _____ (c) Social Security No. _____

4. Sex Female 5. Color or Race White 6. (a) Single, married, widowed or divorced Infant
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife, if alive _____ yrs.

7. Birthdate of deceased Feb. 4, 1945
(Month) (Day) (Year)

8. AGE: Years 3 Months 28 Days _____ If less than one day
hrs. _____ min. _____

9. Birthplace Casa Grande, Arizona
(City, town or county) (State or Country)

10. Usual Occupation Infant

11. Industry or Business _____

12. Name Curry A. Fautner
13. Birthplace Missouri
(City, town or county) (State or Country)

14. Maiden Name Elizabeth Howe
15. Birthplace Oklahoma
(City, town or county) (State or Country)

16. (a) Informant's own signature P. D. Fautner
(b) Address Casa Grande, Ariz. San. Del.

17. (a) Burial, Cremation or Removal Buried
(b) Place Casa Grande (c) Date June 3, 1945

18. (a) Embalmer's Signature Walter H. Cole
(b) Funeral Director Calvin Mann of Phoenix
(c) Address Casa Grande, Arizona

19. (a) 6-4-45
(Date received local Registrar)
(b) Geraldine Kilcrease
(Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH (Month, day and year) June 2, 1945
TIME (Hour and minute) 8 A.M.

21. I hereby certify that I attended the deceased from 3/2/45 to 6/2/45
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Enteritis
Acute

Due to malnutrition

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 [Address] Date signed 6/4/45

DURATION

PHYSICIAN

Underline the cause to which death should be charged statistically