STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

ARIZONA STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL STATISTICS

8

State File No. .....
Registrar's No. .....

1. Place of Death: (a) County Apache (b) City or Town St Johns (If outside city limits also write RURAL) (c) Location Own home (St. & No. (or) Name of Institution)

(d) Length of Stay: In Hospital or Institution ..... ; In Community 40 years (Specify whether years, months or days) ; In Arizona 40 years

2. Usual Residence of Deceased: (a) State Arizona ; (b) County Apache ; (c) City or Town St Johns (If outside city limits also write RURAL)

(d) Street No. ..... ; (e) Citizen of foreign country (Yes or No) No
If Yes, which country .....

3. (a) FULL NAME Annie Johanneh Davis (b) If Veteran name war ..... (c) Social Security No. none

4. Sex fe

5. Race White ☒ Indian ☐ Negro ☐ Oriental ☐

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

6. (b) Name of husband Alma Davis

6. (c) Age of husband ~~deceased~~, if alive 74 yrs.

7. Birthdate of deceased Sept (Month) 22 (Day) 1875 (Year)

8. AGE: Years 69 Months +10 Days ..... If less than one day hrs. ..... min. .....

9. Birthplace Ephraim (City, town or county) Utah (State or Country)

10. Usual Occupation Housewife

11. Industry or Business Own home

Father
12. Name Marcus H Petersen
13. Birthplace ? (City, town or county) Denmark (State or Country)

Mother
14. Maiden Name Amelia Anderson
15. Birthplace ? (City, town or county) Denmark (State or Country)

16. (a) Informant's own signature Mark Davis
(b) Address St. Johns Ariz.

17. (a) Burial, ~~Cremation or Removal~~
(b) Place ST. Johns (c) Date July 9, 1945

18. (a) Embalmer's Signature .....
(b) Funeral Director Carl A. Anderson
(c) Address St Johns Arizona

19. (a) July 21 - '45 (Date received Local Registrar)
(b) Ethel Shreeve (Registrar's Signature)

18 30M—100% Rag—5/21/43

MEDICAL CERTIFICATION

20. DATE OF DEATH (Month, day and year) July 7th, 1945;
TIME (Hour and minute) 2:05 P. M.

21. I hereby certify that I attended the deceased from 7/7/45 9:30 AM, 19..... to Death 2:05 PM 19 7/7/45 that I last saw he alive on 2:05 PM 7/7/, 19 45; and that death occurred on the date and hour stated above.

Immediate cause of death Massive Cerebral Hemorrhage

Due to Advanced age and

Due to Arteriosclerosis

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

Major findings:
Of operations .....

Of autopsy .....

DURATION
5 hours

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 N. E. McBride, D.O. M. D.
Address Springerville Date signed 7-9-45