

STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

ARIZONA STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL STATISTICS

State File No. 24

Registrar's No. _____

1. Place of Death: (a) County Apache (b) City or Town Cagar (c) Location LaSueur Home
(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 same
(Specify whether years, months or days)

2. Usual Residence of Deceased: (a) State Arizona; (b) County Apache; (c) City or Town Cagar
(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 Jeffrey Whiting Shumway (b) If Veteran name war no (c) Social Security No. none

4. Sex Male 5. Race White Indian Negro Oriental 6. (a) Single, married, widowed or divorced Infant

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

7. Birthdate of deceased July 21st 1945
(Month) (Day) (Year)

8. AGE: Years _____ Months 2 1/2 Days _____ If less than one day hrs. _____ min. _____

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

10. Usual Occupation Infant

11. Industry or Business _____

Father 12. Name Wilford Shumway

13. Birthplace Taylor, Arizona
(City, town or county) (State or Country)

Mother 14. Maiden Name Mable Whiting

15. Birthplace St. Johns, Arizona
(City, town or county) (State or Country)

X 16. (a) Informant's own signature Mabel Shumway

(b) Address St. Johns, Arizona

17. (a) Burial, ~~removal~~ or Removal _____

(b) Place St. Johns (c) Date 7-25 1945

18. (a) Embalmer's Signature _____

(b) Funeral Director Carl Anderson

(c) Address St. Johns, Arizona

X 19. (a) August 12, 1945
(Date received Local Registrar)

(b) Max H. Heaster
(Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH (Month, day and year) July 24, 1945;
TIME (Hour and minute) 3:20 P.M. M.

21. I hereby certify that I attended the deceased from July 21st, 1945 to July 24, 1945;

that I last saw h.i.m. alive on July 24, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Deterius Neonatorum

Due to Faulty Embryological development

Due to _____

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 N. C. McBride M. D.

Address Springerville Date signed July 24, 1945

DURATION 2 1/2 days

PHYSICIAN Underline the cause to which death should be charged statistically