

STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF COMMERCE
BUREAU OF CENSUS

ARIZONA STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL STATISTICS

State File No. 282

1. Place of Death: (a) County Maricopa (b) City or Town Phoenix (c) Location Good Samaritan Hosp
(If outside city limits also write RURAL) (St. & No. (or) Name of Institution)
(d) Length of Stay: In Hospital or Institution Two Weeks; In Community 2 weeks; In Arizona 18 yrs
(Specify whether years, months or days)

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

3. (a) FULL NAME Verda Stewart (b) If Veteran name war No (c) Citizen of foreign country (Yes or No) No
(d) Street No. _____ (e) Social Security No. _____

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

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

7. Birthdate of deceased June 28 - 1923
(Month) (Day) (Year)

8. AGE: Years 22 Months _____ Days _____ If less than one day hrs. _____ min. _____

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

10. Usual Occupation Housewife

11. Industry or Business _____

12. Name Jack Reynolds

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

14. Maiden Name Luster-Melissa Jane

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

16. (a) Informant's own signature Robt Stewart
(b) Address Safford, Ariz

17. (a) Burial, Cremation or Removal Removal
(b) Place Safford, Ariz

18. (a) Embalmer's Signature [Signature]
(b) Funeral Director 451 Grinshaw Mortuary
(c) Address 334 W Monroe St, Phoenix

19. (a) AUG 23 1945
(Date received Local Registrar)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH (Month, day and year) 8-22-45
TIME (Hour and minute) 11:50 M.

21. I hereby certify that I attended the deceased from 8-15-45 to 8-22-45
that I last saw h. OK alive on 8-22-45,
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Partial Intestinal Obstruction

Due to Adhesions

Other conditions (include pregnancy within three months of death) _____

Major findings: Of operations same

Of autopsy same

DURATION
30 days
5 yrs
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] Date signed 8-23-45 M. D.

Address [Signature]