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1-12-45

ARIZONA STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH  
DEPARTMENT OF COMMERCE  
BUREAU OF CENSUS

State File No. 265

Registrar's No. 225

1. Place of Death: (a) County Maricopa (b) City or Town Mesa (c) Location Southside Clinic  
(If outside city limits also write RURAL) (St. & No. (or) Name of Institution)

(d) Length of Stay: In Hospital or Institution 2 days; In Community 2 days; In Arizona 2 days  
(Specify whether years, months or days)

2. Usual Residence of Deceased: (a) State Ariz.; (b) County Maricopa; (c) City or Town Mesa  
(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 Edgar Dwain Graves (b) If Veteran name war \_\_\_\_\_ (c) Social Security No. None

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

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

7. Birthdate of deceased Dec. 13, 1945  
(Month) (Day) (Year)

8. AGE: Years XX Months XX Days 2 hrs. \_\_\_\_\_ min. \_\_\_\_\_  
If less than one day

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

10. Usual Occupation none

11. Industry or Business \_\_\_\_\_

Father { 12. Name William Graves  
13. Birthplace Okla.  
(City, town or county) (State or Country)

Mother { 14. Maiden Name Viola Faultner  
15. Birthplace Okla.  
(City, town or county) (State or Country)

16. (a) Informant's own signature William Graves  
(b) Address Phoenix, Ariz.

17. (a) Burial, Cremation or Removal burial  
(b) Place Tempe, Ariz. (Date) Dec. 17, 1945

18. (a) Embalmer's Signature \_\_\_\_\_  
(b) Funeral Director Carr Mortuary  
(c) Address Tempe, Ariz.

19. (a) Dec. 22, 1945  
(Date received Local Registrar)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH (Month, day and year) Dec. 15, 1945  
TIME (Hour and minute) 6 A.

21. I hereby certify that I attended the deceased from Dec. 13<sup>th</sup> 1945  
to Dec 15<sup>th</sup> 1945

that I last saw him alive on Dec 13<sup>th</sup> 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis

Due to Instrument Birth

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

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

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

DURATION

\_\_\_\_\_

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 [Address] Date signed 12-16-45