

SOCIAL SECURITY NO.

Arizona State Board of Health

81

STANDARD CERTIFICATE OF DEATH

BUREAU OF VITAL STATISTICS

State File No. \_\_\_\_\_

1. PLACE OF DEATH  
 County Gila State ARIZONA Registered No. \_\_\_\_\_  
 Township \_\_\_\_\_ or Village \_\_\_\_\_  
 City San Carlos No. San Carlos Indian Hospital St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (If death occurred in a hospital or institution, give its NAME instead of street and number)  
 Length of residence in city or town where death occurred... yrs. ... mos. ... ds. How long in U. S. if of foreign birth? ... yrs. ... mos. ... ds.  
 2. FULL NAME Un-Named Baby Boy Randall How long in State when death occurred? ... yrs. ... mos. ... ds.  
 (a) Residence: San Carlos, Arizona (Usual place of abode) (If non-resident give city or town and state)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE Apache-Indian 5. SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word) Single  
 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_  
 6. DATE OF BIRTH (month, day, and year) 4-10-46  
 7. AGE Years \_\_\_\_\_ Months \_\_\_\_\_ Days 1 If LESS than 1 day, 9 hrs. or 10 min. \_\_\_\_\_  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_  
 12. BIRTHPLACE (city or town) San Carlos, Arizona (State or Country) \_\_\_\_\_  
 MOTHER 13. NAME Alfonso Randall  
 14. BIRTHPLACE (city or town) San Carlos Arizona (State or Country) \_\_\_\_\_  
 15. MAIDEN NAME Freida Clayton  
 16. BIRTHPLACE (city or town) San Carlos Arizona (State or Country) \_\_\_\_\_  
 17. INFORMANT Mother's Hospital Record (Address) \_\_\_\_\_  
 18. BURIAL, CREMATION, OR REMOVAL Burial  
 Place San Carlos Date 4-13 1946  
 19. EMBALMER { License No. None  
 Signature \_\_\_\_\_  
 FUNERAL DIRECTOR \_\_\_\_\_  
 Address \_\_\_\_\_  
 20. Filed 4-12-46 Robert D. Cunningham Registrar

21. DATE OF DEATH (month, day, and year) 4-12-1946  
 22. I HEREBY CERTIFY, That I attended deceased from April 10, 1946, to April 12, 1946  
 I last saw him alive on April 12, 1946; death is said to have occurred on the date stated above, at 5:55 a.m.  
 The principal cause of death and related causes of importance were as follows:  
157 - Congenital malformation of Urinary Tract at birth  
 Date of Onset \_\_\_\_\_  
 Other contributory causes of importance: \_\_\_\_\_  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? No  
 23. If death was due to external causes (violence) fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county and State)  
 Specify whether injury occurred in industry, in home, or in public place \_\_\_\_\_  
 Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_  
 24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) Robert D. Cunningham M. D.  
 (Address) San Carlos, Arizona

MARGIN RESERVED FOR BINDING  
 N. B. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.