

120

STANDARD CERTIFICATE OF DEATH  
DEPARTMENT OF COMMERCE  
BUREAU OF CENSUS

ARIZONA STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL STATISTICS

State File No. **106**

Registrar's No. **8**

1. Place of Death: (a) County **GILA** (b) City or Town **GLOBE** (c) Location **Gila General Hospital**  
(If outside city limits also write RURAL) (St. & No. (or) Name of Institution)

(d) Length of Stay: In Hospital or Institution **10 days**; In Community **48 years**; In Arizona **56 years**  
(Specify whether years, months or days)

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

(d) Street No. **2276 Oak St Globe Ariz**; (e) Citizen of foreign country (Yes or No) \_\_\_\_\_

3. (a) FULL NAME **MARY Mc Donough** (b) If Veteran name war \_\_\_\_\_ (c) Social Security No. **None**

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

(b) Name of husband or wife **John Nelson Mc Donough** 6. (c) Age of husband or wife, if alive \_\_\_\_\_ yrs.

7. Birthdate of deceased **Oct 13-1856**  
(Month) (Day) (Year)

8. AGE: Years **90** Months **3** Days **15** If less than one day  
hrs min

9. Birthplace **GLASGOW, SCOTLAND**  
(City, town or county) (State or Country)

10. Usual Occupation **Housewife**

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

Father { 12. Name **unknown, Welsh**  
13. Birthplace **Scotland**  
(City, town or county) (State or Country)

Mother { 14. Maiden Name **Marg E. Welsh**  
15. Birthplace **Scotland**  
(City, town or county) (State or Country)

16. (a) Informant's own signature **A. J. Bennett**  
(b) Address **West Maple Globe Ariz**

17. (a) Burial, Cremation or Removal **Burial**  
(b) Place **Globe** (c) Date **1-31** 19**47**

18. (a) Embalmer's Signature **J. Mey Miles Jr.**  
(b) Funeral Director **J. Mey Miles Jr.**  
(c) Address **Globe, Ariz**

19. (a) **Jan. 5 - 47**  
(Date received Local Registrar)  
(b) **June Wauvel**  
(Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH (Month, day and year) **JAN 28**, 19**47**  
TIME (Hour and minute) **10:20**

21. I hereby certify that I attended the deceased from **1/10/47** A.M. to **1/28**, 19**47**  
that I last saw **her** alive on **1/28**, 19**47**

and that death occurred on the date and hour stated above.  
Immediate cause of death **Cerebral hemorrhage**

Due to **senility + Arterio sclerosis**

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 **C. Hunter** M. D.  
Address **Globe** Date signed **1/30/47**