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# ARIZONA STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF COMMERCE
BUREAU OF CENSUS

State File No.
Registrar's No.

1. Place of Death: (a) County Gila (b) City or Town San Carlos (If outside city limits also write RURAL) (c) Location San Carlos Hospital (St. & No. (or) Name of Institution)
(d) Length of Stay: In Hospital or Institution 7 hrs. (Specify whether years, months or days); In Community Life; In Arizona Life
2. Usual Residence of Deceased: (a) State Arizona; (b) County Graham; (c) City or Town Bylas (If outside city limits also write RURAL)
(d) Street No. Rural; (e) Citizen of foreign country (Yes or No)
If Yes, which country --
3. (a) FULL NAME PRESTON, Marietta (b) If Veteran name war (c) Social Security No.

4. Sex: Female
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: July (Month) 3, (Day) 1946 (Year)
8. AGE: Years 1 Months 9 Days 7 If less than one day hrs. -- min. --
9. Birthplace Bylas Graham (City, town or county) Arizona (State or Country)
10. Usual Occupation Infant
11. Industry or Business ---
Father: 12. Name Albert Preston
13. Birthplace San Carlos, (City, town or county) Arizona (State or Country)
Mother: 14. Maiden Name Lucille Dona
15. Birthplace San Carlos, (City, town or county) Arizona (State or Country)
16. (a) Informant's own signature Census roll
(b) Address
17. (a) Burial, Cremation or Removal Burial
(b) Place Bylas (c) Date April 11 1948
18. (a) Embalmer's Signature
(b) Funeral Director --
(c) Address --
19. (a) 4/30/48 (Date received Local Registrar)
(b) H W Barber, MD (Registrar's Signature)

## MEDICAL CERTIFICATION

20. DATE OF DEATH (Month, day and year) April 10 1948;
TIME (Hour and minute) 1:40 a. m. M.
21. I hereby certify that I attended the deceased from Unattended, 19 ; , 19 to , 19 ;
that I last saw h alive on
and that death occurred on the date and hour stated above.

| | DURATION |
|---|---|
| Immediate cause of death unknown | |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within three months of death) | |
| Major findings: Of operations | |
| Of autopsy | |

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 H W Barber M. D.
Address San Carlos Ariz Date signed 4/30/48

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