

1460

STANDARD CERTIFICATE OF DEATH  
FEDERAL SECURITY AGENCY  
U. S. PUBLIC HEALTH SERVICE  
NATIONAL OFFICE OF VITAL STATISTICS

ARIZONA STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL STATISTICS

State File No. **3884**  
Registrar's No. **1507**  
Location **Good Sam. Hosp.**  
(St. & No. (or) Name of Institution)  
**45 years**

1. Place of Death: (a) County **Maricopa** (b) City or Town **Phoenix**  
(If outside city limits also write RURAL) (c) Location  
(d) Length of Stay: In Hospital or Institution **10 days**; In Community **10 Days**  
(Specify whether years, months or days) In Arizona **45 years**

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. **Globe, Arizona**

3. (a) FULL NAME **Jonah F. Nichols** (b) If veteran name war **None** (c) Social Security No. **None**

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

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

7. Birthdate of deceased **April 19, 1869**  
(Month) (Day) (Year)

8. AGE: Years **79** Months **3** Days **11** If less than one day \_\_\_\_\_ hrs \_\_\_\_\_ min.

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

10. Usual Occupation **Retired Clerk**

11. Industry or Business **General Store**

12. Name **Unknown**  
Father { 13. Birthplace **Arkansas**  
(City, town or county) (State or Country)

14. Maiden Name **Unknown**  
Mother { 15. Birthplace **Arkansas**  
(City, town or county) (State or Country)

16. (a) Informant's own signature **Aletha Bly**  
(b) Address **105 S. W. 29th, Oklahoma City, Okla.**

17. (a) Burial, Cremation or Removal **removal**  
(b) Place **Thatcher, Ariz.** (c) Date **8-1-48** 19\_\_

18. (a) Embalmer's Signature **Leo Nussbaum**  
(b) Funeral Director **W. L. Murphy**  
(c) Address **Whitney Funeral Home.**

19. (a) **AUG 3 1948**  
(Date received Local Registrar)  
(b) **M. Rev. D. S. [Signature]**  
(Registrar's Signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH (Month, day and year) **7-30-48**, 19\_\_  
TIME (Hour and minute) **1:45 P.** M.

21. I hereby certify that I **did not see** the deceased **alive**  
that I last saw him **alive on** \_\_\_\_\_, 19\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death **Arteriosclerotic heart disease with acute thrombotic coronary occlusion**

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

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

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

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy **As stated above**

**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 **Delph H. Fuller** M. D.  
Address **Good Samaritan Hosp** signed **7-31-48**