

440

ARIZONA STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL STATISTICS

STATE FILE NO. 196

CERTIFICATE OF DEATH

REGISTRAR'S NO. 55

PLACE OF DEATH AND RESIDENCE	1. PLACE OF DEATH A. COUNTY <i>Greenlee</i>			2. USUAL RESIDENCE (WHERE DECEASED LIVED. IF INSTITUTION: RESIDENCE BEFORE ADMISSION). A. STATE <i>Arizona</i> B. COUNTY <i>Greenlee</i>		
	B. CITY (IF OUTSIDE CORPORATE LIMITS, WRITE RURAL) <i>Morenci</i>			C. CITY (IF OUTSIDE CORPORATE LIMITS, WRITE RURAL) OR TOWN <i>Clifton</i>		
	C. LENGTH OF STAY IN THIS PLACE IN ARIZONA			D. STREET ADDRESS (IF RURAL, GIVE LOCATION) <i>Chase Creek</i>		
	D. FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Morenci Hospital</i>					
DECEDENT PERSONAL DATA	3. NAME OF DECEASED (TYPE OR PRINT) <i>DIANA WADE</i>			4. SEX <i>female</i>		5. COLOR OR RACE <i>white</i>
	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7. DATE OF BIRTH MONTH <i>12</i> DAY <i>22</i> YEAR <i>49</i>		8. AGE YEARS MONTHS DAYS	
	9A. USUAL OCCUPATION (GIVE KIND OF WORK DURING MOST OF LIFE, EVEN IF RETIRED).		9B. KIND OF BUSINESS OR INDUSTRY <i>Arizona</i>		10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>U.S.A.</i>	
	11. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		12. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, WAR OR DATES OF SERVICE)		13. SOCIAL SECURITY NO.	
	14A. FATHER'S NAME <i>Ray Wade</i>		14B. BIRTHPLACE (STATE OR COUNTRY) <i>Colorado</i>		15A. MOTHER'S MAIDEN NAME <i>Ava meek</i>	
15B. BIRTHPLACE (STATE OR COUNTRY) <i>Colorado</i>		16. INFORMANT'S SIGNATURE <i>Mrs Ray D Wade</i>		17. DATE OF DEATH (MONTH) <i>12</i> (DAY) <i>22</i> (YEAR) <i>49</i>		
CAUSE OF DEATH (EM 18)	18. CAUSE OF DEATH ENTER ONLY ONE CAUSE PER LINE FOR (B), (D), (C). *THIS DOES NOT MEAN THE MODE OF DYING, SUCH AS HEART FAILURE, ASTHENIA, ETC. IT MEANS THE DISEASE, INJURY, OR COMPLICATION WHICH CAUSED DEATH. <input checked="" type="checkbox"/> PLACE DISEASE CONTRACTED.					MEDICAL CERTIFICATION
	I. DISEASE OR CONDITIONS DIRECTLY LEADING TO DEATH* (a) <i>Born dead</i>					INTERVAL BETWEEN ONSET AND DEATH
	II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATING TO THE DISEASE OR CONDITION CAUSING DEATH <i>no movement or foetal heart tones noted 48 hrs before birth.</i>					ANTECEDENT CAUSES MORBID CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CAUSE LAST DUE TO (C) <i>unknown</i>
OPERATIONS, AUTOPSY	19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
	21A. ACCIDENT SUICIDE HOMICIDE (SPECIFY)		21B. PLACE OF INJURY (E. G., IN OR ABOUT HOME, FARM, FACTORY, STREET, OFFICE BLDG., ETC.)		21C. (CITY OR TOWN) (COUNTY) (STATE)	
DEATH DUE TO FATAL INJURY	21D. TIME (MONTH) (DAY) (YEAR) (HOUR) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
	22. I HEREBY CERTIFY THAT I ATTENDED THE DECEASED FROM <i>Dec 22 1949</i> TO <i>Dec 22 1949</i> THAT I LAST SAW THE DECEASED <i>live on Dec 22, 1949</i> AND THAT DEATH OCCURRED AT <i>M.</i> FROM THE CAUSES AND ON THE DATE STATED ABOVE.					
MEDICAL ATTENDING PHYSICIAN'S CERTIFICATION	23A. SIGNATURE (DEGREE OR TITLE) <i>C. H. Langhorne M.D.</i>			23B. ADDRESS <i>Clifton, Ariz</i>		23C. DATE SIGNED <i>12-22-49</i>
	24A. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> REMOVAL <input type="checkbox"/>		24B. DATE <i>12-22-49</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Paternal</i>	
FUNERAL DIRECTOR AND REGISTRAR	24D. LOCATION (CITY, TOWN, OR COUNTY) (STATE) <i>Morenci</i>		25A. DATE REC'D BY LOCAL REG. <i>DEC 24 1949</i>		25B. REGISTRAR'S SIGNATURE <i>Gay Strickland</i>	
	26. FUNERAL DIRECTOR'S SIGNATURE <i>Family</i>		27. EMBALMER'S SIGNATURE <i>Clifton</i>			
	27. EMBALMER'S SIGNATURE		CERT. NO.			