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Dr. Callopy

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ARIZONA STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL STATISTICS
CERTIFICATE OF DEATH

STATE FILE NO.

BIRTH NO. 4765

REGISTRAR'S NO. 47

4 5 102 5 2 1 2 206 0 149 149 149 1 8 2 1 3 1 19 19 AR	1. PLACE OF DEATH A. COUNTY <u>Alle</u>			2. USUAL RESIDENCE (WHERE DECEASED LIVED, IF INSTITUTION; RESIDENCE BEFORE ADMISSION) A. STATE <u>Arizona</u> B. COUNTY <u>Bila</u>		
	B. CITY (IF OUTSIDE CORPORATE LIMITS, WRITE RURAL) OR TOWN <u>Miami</u>		C. LENGTH OF STAY IN THIS PLACE IN ARIZONA <u>6 mos</u> <u>6 mos.</u>		C. CITY (IF OUTSIDE CORPORATE LIMITS, WRITE RURAL) OR TOWN <u>Miami</u>	
D. FULL NAME OF HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>Miami Sinspiter Hospital</u>				D. STREET ADDRESS (IF RURAL, GIVE LOCATION) <u>106 Red Springs Canyon</u>		
3. NAME OF DECEASED A. (FIRST) <u>Catalina</u> B. (MIDDLE) <u>Ruiz</u> C. (LAST) <u>Mujia</u>			4. SEX <u>Female</u>	5. COLOR OR RACE <u>White</u>		
6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7. DATE OF BIRTH MONTH <u>March</u> DAY <u>19</u> YEAR <u>1949</u>		8. AGE YEARS <u>6</u> MONTHS <u>6</u> DAYS <u>-</u>	9A. USUAL OCCUPATION (GIVE KIND OF WORK DURING MOST OF LIFE, EVEN IF RETIRED). <u>None</u>	
9B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Arizona</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		12. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, WAR OR DATES OF SERVICE) <u>no</u>
13. SOCIAL SECURITY NO.		14A. FATHER'S NAME <u>Natividad Mujia</u>		14B. BIRTHPLACE (STATE OR COUNTRY) <u>New Mexico</u>		15A. MOTHER'S MAIDEN NAME <u>Heriberto Ruiz</u>
15B. BIRTHPLACE (STATE OR COUNTRY) <u>New Mexico</u>		16. INFORMANT'S SIGNATURE <u>Natividad Mujia Miami Ariz</u>			17. DATE OF DEATH MONTH <u>0</u> DAY <u>19</u> YEAR <u>1949</u>	
18. CAUSE OF DEATH ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), (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. PLACE DISEASE CONTRACTED.			MEDICAL CERTIFICATION I. DISEASE OR CONDITIONS DIRECTLY LEADING TO DEATH* (a) <u>Vaccinator Collopy</u> ANTECEDENT CAUSES MORBID CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (a) STATING THE UNDERLYING CAUSE LAST. DUE TO (b) <u>Urinary Pneumonia</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATING TO THE DISEASE OR CONDITION CAUSING DEATH.			INTERVAL BETWEEN ONSET AND DEATH <u>sixteen hours</u>
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)		
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 <u>Sept 18</u> , 19 <u>49</u> TO <u>Sept 19</u> , 19 <u>49</u> . THAT I LAST SAW THE DECEASED ALIVE ON <u>Sept 19</u> , 19 <u>49</u> , AND THAT DEATH OCCURRED AT <u>4:30 P.M.</u> , FROM THE CAUSES AND ON THE DATE STATED ABOVE.						
23A. SIGNATURE <u>Dr. Callopy M.D.</u>			23B. ADDRESS <u>Box 623 Miami, Ariz</u>		23C. DATE SIGNED <u>9-22-49</u>	
24A. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> REMOVAL <input type="checkbox"/>		24B. DATE <u>Sept. 20 1949</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Pineapple Cemetery</u>		24D. LOCATION (CITY, TOWN, OR COUNTY) (STATE) <u>Miami Ariz</u>
25. DATE REC'D BY LOCAL REG. <u>Sept 25 1949</u>		25B. REGISTRAR'S SIGNATURE <u>Steven D. Dayton</u>		26. FUNERAL DIRECTOR'S SIGNATURE <u>Rita S. Miles</u> ADDRESS <u>Miami Ariz</u>		