

ARIZONA STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL STATISTICS

STATE FILE NO.

3588

CERTIFICATE OF DEATH

REGISTRAR'S NO.

7-10-50 PLACE OF DEATH 5 RESIDENCE 5	1. PLACE OF DEATH A. COUNTY <i>Maricopa</i>		2. USUAL RESIDENCE (WHERE DECEASED LIVED, IF INSTITUTION; RESIDENCE BEFORE ADMISSION, IF INSTITUTION; RESIDENCE BEFORE ADMISSION, IF INSTITUTION; RESIDENCE BEFORE ADMISSION, IF INSTITUTION.) A. STATE <i>Arizona</i>	
	B. CITY (IF OUTSIDE CORPORATE LIMITS, WRITE OR RURAL) <i>Wickenburg</i>		B. COUNTY <i>Maricopa</i>	
	C. LENGTH OF STAY IN THIS PLACE IN ARIZONA <i>12 hrs. 19 yrs.</i>		C. CITY (IF OUTSIDE CORPORATE LIMITS, WRITE OR RURAL) <i>Wickenburg</i>	
11 IDENTIFICATION 187 7 250	3. NAME OF DECEASED A. (FIRST) <i>William</i>			4. SEX <i>male</i>
	B. (MIDDLE) <i>Joseph</i>		5. COLOR OR RACE <i>white</i>	
	C. (LAST) <i>Helme</i>			
000 USE OF ATH M 181 0	6. MARRIED NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7. DATE OF BIRTH MONTH <i>Oct</i> DAY <i>13</i> YEAR <i>1862</i>	
	8. AGE YEARS <i>87</i> MONTHS <i>9</i> DAYS <i>15</i>		9A. USUAL OCCUPATION (GIVE KIND OF WORK DURING MOST OF LIFE, EVEN IF RETIRED) <i>Retired Ship Builder</i>	
	9B. KIND OF BUSINESS OR INDUSTRY <i>Ship Building</i>		10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New York</i>	
ATIONS, OPSY ATH E TO RNAL ENCE	11. CITIZEN OF WHAT COUNTRY? <i>USA</i>		12. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, WAR OR DATES OF SERVICE) <i>no</i>	
	13. SOCIAL SECURITY NO. <i>none</i>		14A. FATHER'S NAME <i>James F. Helme</i>	
	14B. BIRTHPLACE (STATE OR COUNTRY) <i>Fla.</i>		15A. MOTHER'S MAIDEN NAME <i>Deborah Helme</i>	
ICAL RNER'S ICATION	16. INFORMANT'S SIGNATURE <i>Anna S. Helme</i>		17. DATE OF DEATH (MONTH) (DAY) (YEAR) <i>July 29 1950</i>	
	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 CONTRACTIONS.		MEDICAL CERTIFICATION I. DISEASE OR CONDITIONS DIRECTLY LEADING TO DEATH* (a) <i>Uremia</i>	
	II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATING TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Prostatic Abscess</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7 years.</i>	
ERAL CTOR ND TRAR	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.)	
TRAR	21C. (CITY OR TOWN) (COUNTY) (STATE)			
	21D. TIME (MONTH) (DAY) (YEAR) (HOUR) (MINUTE) (SECOND) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
	21F. HOW DID INJURY OCCUR?			
TRAR	22. I HEREBY CERTIFY THAT I ATTENDED THE DECEASED FROM <i>10-19</i> 19 <i>48</i> TO <i>7-28</i> 19 <i>50</i> . THAT I LAST SAW THE DECEASED ALIVE ON <i>7-27</i> 19 <i>50</i> AND THAT DEATH OCCURRED <i>12:30 AM</i> FROM THE CAUSES AND ON THE DATE STATED ABOVE.			
	23A. SIGNATURE (DEGREE OR TITLE) <i>William H. Henry, M.D.</i>		23B. ADDRESS <i>Wickenburg, Ariz.</i>	
	23C. DATE SIGNED <i>8-1-50</i>			
TRAR	24A. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> REMOVAL <input type="checkbox"/>		24B. DATE <i>7-30-50</i>	
	24C. NAME OF CEMETERY OR CREMATORY <i>Wickenburg</i>		24D. LOCATION (CITY, TOWN, OR COUNTY) (STATE) <i>Wickenburg Ariz.</i>	
	25A. DATE REC'D BY LOCAL REG. <i>8-3-50</i>		25B. REGISTRAR'S SIGNATURE <i>Mami Coffinger</i>	
TRAR	25C. FUNERAL DIRECTOR'S SIGNATURE <i>H. L. Coffinger</i>		25D. ADDRESS <i>Wickenburg Ariz.</i>	
	25E. EMBALMER'S SIGNATURE <i>H. L. Coffinger</i>		25F. CERT. NO. <i>189-4</i>	