

1536

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County Maricopa
District _____
Town Phoenix
or City _____

ARIZONA STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

State Index - - No. 283
County Registrar's No. 180
Local Registrar's - No. 189

ORIGINAL CERTIFICATE OF DEATH
Arizona State Hospital

FULL NAME W. L. T. Early
(If death occurred in a hospital or institution, give its NAME instead of street and number)
(a) Residence. No. 730 E. McDowell
(Usual place of abode)
City or town where death occurred _____ St. _____ Ward _____
How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

1. SEX Male
2. COLOR or RACE White
3. SINGLE, MARRIED, WIDOWED or DIVORCED Married
(write the word)

5a. If married, widowed, or divorced Married
HUSBAND of _____
(or) WIFE of _____

6. DATE OF BIRTH (month, day and year) _____

7. AGE 68
Years Months Days
IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED Physician
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Texas
(State or country)

10. NAME OF FATHER Abner Early

11. BIRTHPLACE OF FATHER (city or town) Miss
(State or country)

12. MAIDEN NAME OF MOTHER Frank

13. BIRTHPLACE OF MOTHER (city or town) Texas
(State or country)

14. Informant Walter Early
(Address) _____

15. Filed 2-2, 1923 I. L. GARRISON, M.
V. S. No. 1 2-12-23 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (month, day, and year) _____ 1923
17. _____

I HEREBY CERTIFY, That I attended deceased from Jan 12, 1923 to Jan 21, 1923
that I last saw him alive on Jan 21, 1923
and that death occurred, on the date stated above, at 11:12 a.m.
The CAUSE OF DEATH* was as follows:
suicide

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (Secondary) _____
(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted _____
if not at place of death? _____

Did an operation precede death? _____ Date of _____
Was there an autopsy? _____

What test confirmed diagnosis? _____
(Signed) A. E. Young, M. D.
19 (Address) _____

* State the Disease Causing Death, or in deaths from violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION OR REMOVAL Granwood DATE OF BURIAL 2/2/23

20. UNDERTAKER Marymount ADDRESS _____