433

STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF COMMERCE
BUREAU OF CENSUS

ARIZONA STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL STATISTICS

State File No. 297
Registrar's No. 1335

1. Place of Death: (a) County Maricopa (b) City or Town Phoenix (If outside city limits also write RURAL) (c) Location 718 N. 1st. St. (St. & No. (or) Name of Institution)

(d) Length of Stay: In Hospital or Institution ____; In Community 1 year (Specify whether years, months or days); In Arizona 1 year

2. Usual Residence of Deceased: (a) State Arizona; (b) County Maricopa; (c) City or Town Phoenix (If outside city limits also write RURAL)

(d) Street No. 718 N. 1st. St.

(e) Citizen of foreign country (Yes or No) No
If Yes, which country

3. (a) FULL NAME Thomas H. Haynes (b) If Veteran name war ____ (c) Social Security No. 507-05-6820

4. Sex M
5. Race White ☒ Indian ☐ Negro ☐ Oriental ☐
6. (a) Single, married, widowed or divorced Married
6. (b) Name of husband or wife Bea Haynes
6. (c) Age of husband or wife, if alive 38 yrs.
7. Birthdate of deceased Nov. 26, 1895 (Month) (Day) (Year)
8. AGE: Years 49 Months 8 Days 28 If less than one day ____ hrs. ____ min.
9. Birthplace Kentucky (City, town or county) (State or Country)
10. Usual Occupation none
11. Industry or Business ____

Father
12. Name Clellan Haynes
13. Birthplace Unknown (City, town or county) (State or Country)

Mother
14. Maiden Name Pally Stwngell
15. Birthplace Unknown (City, town or county) (State or Country)

16. (a) Informant's own signature Bea A Haynes
(b) Address 718 N 1st Street

17. (a) Burial, Cremation or Removal Removal
(b) Place Rexburg, Idaho (c) Date Aug 26 1945

18. (a) Embalmer's Signature A H McLellan
(b) Funeral Director A.H. McLellan
(c) Address 617 N. Central Ave.

19. (a) AUG 25 1945 (Date received Local Registrar)
(b) Cecil Hughes M.D. (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH (Month, day and year) 8/24/45, 19__
TIME (Hour and minute) 11 A.M.

21. I hereby certify that I attended the deceased from 8/13/45, 19__ to 8/24/45, 19__
that I last saw him alive on on last date, 19__
and that death occurred on the date and hour stated above.

Immediate cause of death Gastroenteritis & Myocarditis Chr.

Due to ____

Due to ____

Other conditions ____ (Include pregnancy within three months of death)

Major findings:
Of operations ____

Of autopsy ____

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 L. L. Jamison M. D.
Address 540 W. McKinley Date signed 8/25/45

40M—100% Rag—5-10-44