

FILED SEP 4 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29420

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7304**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>Belleville</b> <i>8/20/57</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Anthony's Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>833 Tower</b>	
3. NAME OF DECEASED (Type or print) First <b>Debbie</b> Middle <b>C.</b> Last <b>Fambrough</b>		4. DATE OF DEATH Month <b>August</b> Day <b>2</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 20, 1956</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>California</b>
13. FATHER'S NAME <b>Ben Fambrough</b>		14. MOTHER'S MAIDEN NAME <b>Rosemary Hutchinson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Ben Fambrough, 833 Tower, Belleville, Ill.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Polioencephalitis (bulbar type)</b>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>.080.0</b>			19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour <b>a. m.</b> Month <b>p. m.</b> Day <b>Year</b>			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Camden, Tenn.</b>
21. I attended the deceased from <b>340 P.</b> to <b>3</b> and last saw her/him alive on <b>8/5/57</b> Death occurred at <b>1300 Clair</b> on the date stated above; and to the best of my knowledge, from the cause stated.			
22a. SIGNATURE <b>James H. Hoppe</b> (Degree or title)		22b. ADDRESS <b>1300 Clair</b>	22c. DATE SIGNED <b>8/5/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8-3-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Local</b>	23d. LOCATION (City, town, or county) <b>Camden, Tenn.</b> (State)
24. FUNERAL DIRECTOR <b>Albert H. Hoppe, 4700 Washington Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>AUG 5 '57</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>

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diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

St. Clair Illinois  
 x Belleville x St. Louis  
 x 833 Tower St. Anthony's Hospital  
 August 5, 1937 Fairbrough  
 July 20, 1936 x  
 13 0 1 White Female  
 California None  
 Rosemary Hutchinson Ben Fairbrough  
 Ben Fairbrough, 833 Tower, Belleville, Ill. None

1937  
 18  
 26  
 1937

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was prepared by me, or by ..... Student Embalmer No. .... working under my personal supervision.

Student .....  
 Signature of Student Embalmer

Signed *J. W. B. Embler*  
 Licensed Embalmer No. 365  
 P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. to comply with the above constitutes grounds for revocation of license). If embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.