

A200  
XC-209 85 23  
FILED MAR 27 1959

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-008547

STATE FILE NUMBER  
130

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 130

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Butler</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Butler</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Poplar Bluff</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Qulin</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VA Hospital</b>		Length of stay in lb <b>19 days</b>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Louis</b> Middle <b>Fairbanks</b> Last <b>Fairbanks</b>			4. DATE OF DEATH Month <b>March</b> Day <b>14</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 21, 1888</b>	9. AGE (In years last birthday) <b>70</b> IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> IF UNDER 24 HRS.: Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>		11. BIRTHPLACE (City and state or country) <b>Arthur, Illinois</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>UNKNOWN</b>		13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
14. NAME OF HUSBAND OR WIFE <b>Luie Fairbanks</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes WWI</b>		16. SOCIAL SECURITY NO. <b>487-20-3495</b>	
17. INFORMANT <b>VA Hospital Records</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>NEPHROSCLEROSIS WITH AZOTEMIA.</b> (At least 2 yrs.) DUE TO (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE.</b> few (At least 2 yrs.) DUE TO (c) <b>442x</b>		INTERVAL BETWEEN ONSET AND DEATH <b>At least 2 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>1. CHRONIC CHOLELITHIASIS. 2. CHOLECYSTITIS (At least 2 years.)</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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>12:45 AM</b> Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <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 COUNTY STATE	
21. attended the deceased from <b>March 2-1-59</b> to <b>3-14-59</b> Death occurred at <b>12:45 AM</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Robert S. Cohen, M.D., Chief, Medical Svc VA Hospital, Poplar Bluff, Mo.</b> (Degree or title)		22b. ADDRESS		22c. DATE SIGNED <b>3/16/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Mar. 16, 1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Qulin Cemetery</b>	
23d. LOCATION (City, town, or county) (State) <b>Qulin Missouri</b>		24. FUNERAL DIRECTOR <b>Landess Funeral Home, Campbell, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>3/21/59</b>	
26. REGISTRAR'S SIGNATURE <b>R. Munster</b>					

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

RECEIVED

MAR 25 1958  
BUTLER CO. HEALTH CENTER

FILE No. \_\_\_\_\_

1958

APR 9

STATEMENT BY LICENSED EMBALMER

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

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *Christine M. Landrum*

Licensed Embalmer No. *4227*  
P. O. Address *Campbell*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure 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.