

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 28 1959

59-033039  
STATE FILE NUMBER

Registration District No. 00 Primary Registration District No. 3044 Registrar's No. 164

DEED

1. PLACE OF DEATH a. COUNTY <u>Macon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Macon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Twp</u>		Length of stay in 1b <u>---</u>	c. CITY OR TOWN <u>Excelsior Mo</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>---</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>---</u>
		Yes <input type="checkbox"/> No <input type="checkbox"/>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JERRY</u> Middle <u>Fambin</u> Last <u>Fambin</u>			4. DATE OF DEATH Month <u>9</u> Day <u>17</u> Year <u>59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-8-96</u>	9. AGE (last birthday) <u>63</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>9</u>	IF UNDER 24 HR Hours <u>---</u> Min. <u>---</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mining</u>		11. BIRTHPLACE (City and state or country) <u>Adrian Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>W.G. Fambin</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah E. Carter</u>		14. NAME OF HUSBAND OR WIFE <u>---</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>514-07-4832</u>		17. INFORMANT <u>Daithy Rose Brien</u>		
				Address <u>---</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>		<u>minutes</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Chronic myocarditis</u>	<u>?</u>
	DUE TO (c) <u>Obstructive Emphysema</u>	<u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cor Pulmonale</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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.) <u>---</u>
20c. TIME OF INJURY Hour <u>---</u> e.m. <u>---</u> p.m. <u>---</u>	Month, Day, Year <u>---</u>	

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.) <u>---</u>	20f. CITY, TOWN, OR LOCATION <u>---</u>	COUNTY <u>---</u>	STATE <u>---</u>
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21. I attended the deceased from June 29, 1958 to Sept 15, 1959 and last saw <sup>her</sup> him alive on Sept 13, 1959  
Death occurred at 9 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>W.C. Copley D.O.</u> (Degree or title)	22b. ADDRESS <u>Huntersville Mo</u>	22c. DATE SIGNED <u>9-21-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-19-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Richardsdale Cem</u>	23d. LOCATION (City, town, or county) <u>Berlin Mo</u>
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24. FUNERAL DIRECTOR <u>H.S. Edwards</u>	ADDRESS <u>Berlin Mo</u>	25. DATE RECD. BY LOCAL REG <u>9/21/59</u>	26. REGISTRAR'S SIGNATURE <u>Keith W. Reedy</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 29 1959

STATEMENT BY LICENSED EMBALMER

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

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

Signed *J. G. Edwards*

Licensed Embalmer No. 1961  
P. O. Address *Brewer, Md*

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.