

BUREAU OF VITAL STATISTICS ARIZONA STATE BOARD OF HEALTH STANDARD CERTIFICATE OF DEATH

1. PLACE OF DEATH
 County Cochise State _____ Registered No. 34
 District or Township Douglas or Village _____
 City Douglas No. _____ St. _____ Ward _____
 (If death occurred in a hospital or institution, give its NAME instead of street and number).

2. FULL NAME Timothy Samuel Sambison
 (a) Residence. No. 953-11th Douglas St. _____ Ward _____
 (Usual place of abode) (If non-resident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR or RACE White 5. SINGLE, MARRIED, WIDOWED or DIVORCED. Married
 (Write the word)

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

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

7. AGE Years 66 Months _____ Days _____ IF LESS than 1 day _____ hrs. or _____ min.

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

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

10. NAME OF FATHER Samuel Sambison

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

12. MAIDEN NAME OF MOTHER Mary Armstrong

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

14. Informant Lillian Sambison (Address) 953-11 Douglas

15. Filed 7-15 1925 Q. Carney Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (month, day, and year) 7/14/25 19____

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____, that I last saw him alive on 7/14/25, 19____, and that death occurred, on the date stated above, at 8:50 p.m. The CAUSE OF DEATH* was as follows:
arteriosclerosis
 (duration) 10 yrs. _____ mos. _____ ds.

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

18. Where was disease contracted _____ not at place of death? _____
 Did an operation precede death? _____ Date of _____
 Was there an autopsy? _____
 What test confirmed diagnosis? _____
 (Signed) A. P. Pleunckney, M. D. 7/15/25 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 Douglas Ariz DATE OF BURIAL 7/15/25

20. UNDERTAKER Porter Thomas ADDRESS Douglas

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. See instructions on back of certificate.