

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

31510

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
 Township..... Primary Registration District No. **1003**  
 City: *St. Louis* (No. *2640 & Armand St.*)

File No. ....  
 Registered No. **18814**  
 St. .... Ward)

**2. FULL NAME**

*Emily Fannie Noble*  
 (a) Residence, No. *2640 Armand* St. *23* Ward.  
 (Usual place of abode)  
 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. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widow*

5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (or) WIFE OF *Louis Noble*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *June 23 1853*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>74</i>	<i>3</i>	<i>9</i>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work *at Home*  
 (b) General nature of industry, business, or establishment in which employed (or employer).....  
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) *Granite*  
 (STATE OR COUNTRY) *Illinois*

PARENTS

10. NAME OF FATHER *Ernest Drigger*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Granite*  
 (STATE OR COUNTRY) *Illinois*

12. MAIDEN NAME OF MOTHER *Mary Lamb*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Illinois*  
 (STATE OR COUNTRY) *Illinois*

14. INFORMANT *Mrs. Minnie C. Bange*  
 (Address) *2640 & Armand St.*

15. FILED *1027* *Nov 6 1927* *Max C. Stashoff*  
 REGISTRAR

**3 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Oct 2 1927*

17. I HEREBY CERTIFY, That I attended deceased from *Sept 10* 1927, to *Oct 2* 1927, that I last saw him alive on *Oct 2* 1927, and that death occurred, on the date stated above, at *300 a. m.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Heart block* *12-4-27*  
*118 C*  
*95 A*  
*Non alcoholic* (duration) yrs. mos. ds.

CONTRIBUTORY *slight of heart auto*  
 (SECONDARY) *heart disease* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *at home*

IF NOT AT PLACE OF DEATH, DID AN OPERATION PRECEDE DEATH? *no* DATE OF *10-2-27*

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *clinical*  
 (Signed) *M. O. Washington* M. D.  
 (Address) *1341 Arlington*

\*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Valhalla* DATE OF BURIAL *Oct 4 1927*

20. UNDERTAKER *Hansgar Sheahan WCO* ADDRESS *4415 Washington*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—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.

