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FILED FEB 3 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 3559  
0728

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. \_\_\_\_\_

|   |  |   |      |
|---|--|---|------|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE Missouri<br>b. COUNTY |      |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>St. Louis | c. LENGTH OF STAY (In this place)<br>13 mo | c. CITY (If outside corporate limits, write RURAL and give township)<br>St. Louis                                       | 2219 |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br>Homer G Phillips Hospital              |  | d. STREET ADDRESS (If rural, give location)<br>21 2643 Pine   |      |

|  |                         |  |  |  |                           |  |
|--|-------------------------|--|--|--|---------------------------|--|
| 3. NAME OF DECEASED<br>(Type or Print)<br>L. P. Norment  |                         |  | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br>Jan. 17 1953 |  |                           |  |
| 5. SEX<br>M  | 6. COLOR OR RACE<br>Col | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br>Divorced 3 | 8. DATE OF BIRTH<br>Feb 5 1929                           | 9. AGE (In years last birthday)<br>33                              | 10. UNDER 1 YEAR<br>11 12 | 11. UNDER 24 HRS.<br>Min.              |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Laborer |                         | 10b. KIND OF BUSINESS OR INDUSTRY                                    |  | 11. BIRTHPLACE (City and State or Foreign Country)<br>Marianna Ark |                           | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A. |

|                                      |   |                             |
|--------------------------------------|---|-----------------------------|
| 13a. FATHER'S NAME<br>Samuel Norment | 13b. MOTHER'S MAIDEN NAME<br>Rubie Iyer | 14. NAME OF HUSBAND OR WIFE |
|--------------------------------------|---|-----------------------------|

|  |  |  |                         |
|--|--|--|-------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>No | 16. SOCIAL SECURITY NO.<br>495-36-7925 | 17. INFORMANT'S SIGNATURE OR NAME<br>Rosie Lee Yates | ADDRESS<br>2643 Pine st |
|--|--|--|-------------------------|

|  |  |  |  |                                  |
|--|--|--|--|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)  |  | MEDICAL CERTIFICATION  |  | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis, Far Advanced  |  | DUPLICATE  |  | Undet.                           |
| *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. |  | ANTECEDENT CAUSES  |  |                                  |
|  |  | DUE TO (b) Undetermined  |  |                                  |
|  |  | DUE TO (c)   |  |                                  |
|  |  | II. OTHER SIGNIFICANT CONDITIONS   |  |                                  |
|  |  | Conditions contributing to the death but not related to the disease or condition causing death. None |  |                                  |

|                        |                                  |  |   |
|------------------------|----------------------------------|--|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------|----------------------------------|--|---|

|  |  |   |
|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
|--|--|---|

|  |  |                                    |
|--|--|------------------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR?<br>0024 |
|--|--|------------------------------------|

22. I hereby certify that I attended the deceased from 1-15-1953, to 1-17-1953, that I last saw the deceased alive on 1-17-1953, and that death occurred at 8:20p m., from the causes and on the date stated above.

|  |                   |                                      |                             |
|--|-------------------|--------------------------------------|-----------------------------|
| 23a. SIGNATURE<br>Clara E. Brooks M.D. | (Degree or title) | 23b. ADDRESS<br>2601 N. Whittier St. | 23c. DATE SIGNED<br>1-19-53 |
|--|-------------------|--------------------------------------|-----------------------------|

|  |                        |  |  |
|--|------------------------|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br>Removal | 24b. DATE<br>Jan 22-53 | 24c. NAME OF CEMETERY OR CREMATORY<br>HOLSEBROOK | 24d. LOCATION (City, town, or county) (State)<br>West Helena Ark |
|--|------------------------|--|--|

|   |   |  |                        |
|---|---|--|------------------------|
| DATE REC'D BY LOCAL REG.<br>JAN 22 1953 | REGISTRAR'S SIGNATURE<br>J. Carl Smith MD | 25. FUNERAL DIRECTOR'S SIGNATURE<br>J W Hughes | ADDRESS<br>2620 Lawton |
|---|---|--|------------------------|

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 .....  
Student Embalmer

Signed

*James A. Carter*

Licensed Embalmer No. *24681*

P. O. Address. *St. Louis*

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 this body is not embalmed, fact should be so stated above.