

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019486

STATE FILE NUMBER

2 4343

FILED MAY 18 1959

Registration District No.

Primary Registration District No.

Registrar's No.

300

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Doctor, coroner, etc., must use only standard nomenclature in their report. No symptoms with or without. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST. LOUIS</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Hommer G. Phillips</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>2935 Olive</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Willie Lee Noble</u>			4. DATE OF DEATH Month Day Year <u>5 2 59</u>
5. SEX <u>3</u> <u>Female</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-17-1926</u>
9. AGE (In years, <u>32</u> at birthday) IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and state or country) <u>Greenville, Miss.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>LONZO Lewis</u>	
13b. MOTHER'S MAIDEN NAME <u>Vanilla Lewis</u>		14. NAME OF HUSBAND OR WIFE <u>Will Noble</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	17. INFORMANT <u>Albert C. Triplett</u> Address <u>3042 Pine St.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive hemothorax; stab wound of the</u> <u>heart and aorta,</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>982x</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Suffered when stabbed with knife in hands of one Fannie Jordan (Col) front of about 2912 Pine St. about 1:15 a.m. May 2, 1959.</u>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. <u>1:15 a.m. May 2, 1959.</u>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Street</u>	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20f. CITY, TOWN, OR LOCATION <u>Homicide St. Louis</u> COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Paul M. Dixon</u> (Degree, if any)		22b. ADDRESS <u>1300 Clark</u>	22c. DATE SIGNED <u>5/4/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>5-9-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Father Dickson, Cem. ST. LOUIS COUNTY, Mo.</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS COUNTY, Mo.</u>
24. FUNERAL DIRECTOR <u>Mr. Claw</u> ADDRESS <u>4251 Washington</u>	25. DATE RECD. BY LOCAL REG. <u>MAY 4 '59</u>	26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u>	

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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 *Leroy H. Bannister* .....

Licensed Embalmer No. *4523* .....  
P. O. Address *4251 Wesley* .....

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.