

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 8 1959

59-034031

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 8904**

RECEIVED

| | | | |
|---|---------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY _____ | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY _____ | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | Length of stay in 1b 46 yrs | c. CITY OR TOWN St. Louis | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips | | d. STREET ADDRESS (If outside, give location) 2827 Lucas | |
| | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|--|---|--|--|---|--|--|--|
| 3. NAME OF DECEASED (Type or print) First Louis Middle _____ Last Lennox | | | 4. DATE OF DEATH Month 9 Day 25 Year 59 | | | | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 3/5/1913 | 9. AGE (last birthday) 58 | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life) Garage Attendant | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | | 11. BIRTHPLACE (City and state or country) Haleville, Ky | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME Obie Lenox | | 13b. MOTHER'S MAIDEN NAME Hester Croslin | | 14. NAME OF HUSBAND OR WIFE Alice Gray, 4345 Vinewood, Detroit, Mich | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 494-05-2846 | | 17. INFORMANT Alice Gray, 4345 Vinewood | | | |

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|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma with Metastasis to the Pancreas, Peripancreatic Lymphnodes, Aortic, Mesenteric Lymphnodes and Liver | | INTERVAL BETWEEN ONSET AND DEATH Undet. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | |

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|---|--|--|--|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | |
|---|--|--|--|--|

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|---|---|---|--|---|--|
| 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.) | |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. | | Month, Day, Year _____ | | | |
| 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.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |

21. I attended the deceased from **9-19-59** to **9-25-59** and last saw him alive on **9-25-59**
 Death occurred at **2:00** p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

| | | |
|---|--|---|
| 22a. SIGNATURE (Degree or title) Edward B. Williams M.D. | 22b. ADDRESS 2601 N. Whittier St. | 22c. DATE SIGNED 9-28-59 |
|---|--|---|

| | | | |
|---|------------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 9/30/59 | 23c. NAME OF CEMETERY OR CREMATORY Washington Park | 23d. LOCATION (City, town, or county) (State) St. Louis Co., MO |
|---|------------------------------------|---|--|

| | | |
|---|---|--|
| 24. FUNERAL DIRECTOR ADDRESS Green Funeral Home, 4060 Washington | 25. DATE RECD. BY LOCAL REG. SEP 28 1959 | 26. REGISTRAR'S SIGNATURE Coart Smith, M.D. |
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

with

X
X

46702
X

No. 21

28 1/2 1/2 28

Hester
Hester

Hester
Hester

George Hester
Olin Hester

Original
copy

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 Melvin E. Green

Licensed Embalmer No. 4428

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.