

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-005772

STATE FILE NUMBER

428

FILED FEB 17 1959

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

300  
-57 D

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <del>Missouri</del> <b>Kansas</b> b. COUNTY <del>Jackson</del> <b>Wyandotte</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas CITY</b> 8150 8
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>General Hospital</b>		Length of stay <b>5 yrs</b>	d. STREET ADDRESS (If outside, give location) <b>3301 Delavan</b>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>MAY</b> Last <b>NOBLE</b>	4. DATE OF DEATH Month <b>January</b> Day <b>21</b> Year <b>1959</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 19 1874</b>	9. AGE (In years last birthday) <b>84</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>School Teacher</b>	11. BIRTHPLACE (City and state or country) <b>Chelyan W Virginia</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>James Calvert</b>	13b. MOTHER'S MAIDEN NAME <b>Genthia Tony</b>	14. NAME OF HUSBAND OR WIFE <b>A Jordon Noble</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Norman C Noble 3301 Delavan K C Kansas</b>	Address
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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) <b>Cerebral hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>hours <del>years</del></b> <b>years</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Cerebral arterio sclerosis</b>	
	DUE TO (c)	
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 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.) <b>3:15</b>
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20c. TIME OF INJURY Hour <input type="checkbox"/> o.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <b>Burlingame</b>	COUNTY <b>Kansas</b>	STATE
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21. I attended the deceased <b>on</b> <b>1-21-59</b> to <b>1-21-59</b> and last saw <sup>her</sup> him alive on <b>1-21-59</b> Death occurred at <b>4:00 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>M. A. Cline</b> (Degree or title) <b>M.D.</b>	22b. ADDRESS <b>4126 St. John, K.C., Mo</b>	22c. DATE SIGNED <b>1-24-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>1/24/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Burlingame Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Burlingame Kansas</b>
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24. FUNERAL DIRECTOR <b>Sheil Funeral Home Kansas City Mo</b>	25. DATE RECD. BY LOCAL REG. <b>1-23-59</b>	26. REGISTRAR'S SIGNATURE <b>Neve Marshall</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

M. A. Cline

All diseases in Part I must be causally related.



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 *Thomas A. Phil* .....

Licensed Embalmer No. *4954* .....

P. O. Address *J.C.M.D.* .....

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.