

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **36598**
 9963

FILED NOV 13 1952

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

Registrar's No.

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, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 4039 Garfield	
3. NAME OF DECEASED (Type or Print) a. (First) Dorothy b. (Middle) c. (Last) Lester			4. DATE OF DEATH (Month) (Day) (Year) Oct. 25 1952
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH March 6, 1920
9. AGE (In years last birthday) 32		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	11. BIRTHPLACE (City and State or Foreign Country) Miss.
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY None	12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME Willie Lester		13b. MOTHER'S MAIDEN NAME Fannie McDonald	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)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Fannie McDonald 4039 Garfield
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Decompensation ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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. Anemia and Polycystic Kidney Disease	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? 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? 11343
22. I hereby certify that I attended the deceased from 10-2 , 1952, to 10-25 , 1952, that I last saw the deceased alive on 10-25 , 1952, and that death occurred at 10:30a.m. , from the causes and on the date stated above.			
23a. SIGNATURE Edna E Brooks (Degree or title)		23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 10-27-52
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Oct. 31, 1952	24c. NAME OF CEMETERY OR CREMATORY Washington Park	24d. LOCATION (City, town, or county) (State) St. Louis County Mo.
DATE REC'D BY LOCAL REG. OCT 29 1952	REGISTRAR'S SIGNATURE J. C. Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Lee J. Sneed 3615 Easton Ave.	

(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 Leroy H. Pannister

Licensed Embalmer No. 4523

P. O. Address 3880 Easton Ave

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.