V.S. No. 300
Rev. 10.48

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40529

BIRTH NO. FILED DEC 2 1952 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10540

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Homer G Phillips Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 4323 Washington

2199

3. NAME OF DECEASED (Type or Print): a. (First) Margaret b. (Middle) E c. (Last) Mims

4. DATE OF DEATH (Month) Nov. (Day) 9 (Year) 1952

5. SEX Female 3
6. COLOR OR RACE Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH 3/27/1909
9. AGE (In years last birthday) 43 — 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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None.
11. BIRTHPLACE (City and State or Foreign Country): Henderson. Ky.
12. CITIZEN OF WHAT COUNTRY? U.S.A

13a. FATHER'S NAME: Harvey Estes
13b. MOTHER'S MAIDEN NAME: Comilla Leuis
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT'S SIGNATURE OR NAME: Robert L. Leuis **ADDRESS**: 3035 Franklin

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Carcinoma of Esophagus — INTERVAL BETWEEN ONSET AND DEATH: Undet.

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.* None

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 150X

22. *I hereby certify that I attended the deceased from* 11-6, 19 52, *to* 11-9, 19 52, *that I last saw the deceased alive on* 11-9, 19 52, *and that death occurred at* 3:25 P m., *from the causes and on the date stated above.*

23a. SIGNATURE Earl C Collins
(Degree or title) M. D.
23b. ADDRESS 2601 N Whittier St
23c. DATE SIGNED 11-12-52

24a. BURIAL, CREMATION, REMOVAL (Specify)
24b. DATE
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. NOV 17 1952
REGISTRAR'S SIGNATURE J. Earl Smith M.D.
25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Peoples Und. Co. 3100 Franklin Ave

G.D. (Licensed Embalmer's Statement on Reverse Side)

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 W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Allen

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.