

FILED JUN 24 1954

STANDARD CERTIFICATE OF DEATH

State File No. **21342**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5162**

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 OR TOWN ST LOUIS, MO.	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION: Homer G. Phillips Hospital		e. STREET ADDRESS (If rural, give location) 3941 Finney	2119

3. NAME OF DECEASED (Type or Print)	a. (First) Dorothy	b. (Middle) ESTELLE	c. (Last) Thomas	4. DATE OF DEATH (Month) (Day) (Year) 6 6 54
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5. SEX Female 3	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH NOV 14, 1907	9. AGE (In years last birthday) 46	if UNDER 1 YEAR Months	if UNDER 2 HRS. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAID	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) ST LOUIS, MO	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME CLARENCE THOMAS	13b. MOTHER'S MAIDEN NAME ESTELLE RANDALL	14. NAME OF HUSBAND OR WIFE NONE
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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)	16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT'S SIGNATURE OR NAME Milton L. Thomas	ADDRESS 5225 Old Bullhead
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchogenic Carcinoma of Lung with Metastasis		INTERVAL BETWEEN ONSET AND DEATH Undt.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 162X
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22. I hereby certify that I attended the deceased from **4-19**, 19**54**, to **6-6**, 19**54**, that I last saw the deceased alive on **6-6**, 19**54**, and that death occurred at **12:10 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) E. B. Williams	23b. ADDRESS M.D. 2601 N. Whittier	23c. DATE SIGNED 6-7-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 6-10-54	24c. NAME OF CEMETERY OR CREMATORY Greenwood	24d. LOCATION (City, town, or county) (State) 69th St. Louis, Mo.
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DATE REC'D BY LOCAL REG. JUN 10 1954	REGISTRAR'S SIGNATURE Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Snell	ADDRESS 3615 Koston
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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.....
Signature of Student Embalmer

Signed *Euther R. Harris*

Licensed Embalmer No. *44*

P. O. Address *418 N. Ash*

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.