THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-011452

STATE FILE NO. 23001

FILED APR 6 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis — Inside Limits: Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Homer G. Phillips — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St.Louis — Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 4604 St. Ferdinand — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Dona — Middle: — Last: Thomas

4. DATE OF DEATH: Month 3 — Day 23 — Year 59

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-14-1888

9. AGE (In years last birthday): 70 — 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): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (City and state or country): TENN

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13a. FATHER'S NAME: IKE SHOFFNER

13b. MOTHER'S MAIDEN NAME: UNKNOWN

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.: NONE

17. INFORMANT: ROSE PIERCE — Address: 4604 ST FERDINAND

MEDICAL CERTIFICATION

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

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL THROMBOSIS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 332K

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): ARTERIOSCLEROTIC HEART DISEASE.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

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 ☐ NOT WHILE AT WORK ☐

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 3-18-59, to 3-23-59 and last saw her alive on 3-23-59
Death occurred at 7:45 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Paul M Larson, (Degree or title) M.D.

22b. ADDRESS: 2601 Whittier Street

22c. DATE SIGNED: 3-24-59

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

23b. DATE: 3-30-59

23c. NAME OF CEMETERY OR CREMATORY: WASHINGTON PARK

23d. LOCATION (City, town, or county): ST LOUIS COUNTY — (State): MO

24. FUNERAL DIRECTOR: SWAN-McGHEE — ADDRESS: UNDERTAKERS 1619 UNION

25. DATE RECD. BY LOCAL REG.: MAR 25 '59

26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalm

by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed Edward A. Flynn .....

Licensed Embalmer No. 4444

P. O. Address 4202 Fann

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failu 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.