

APR 19 1943
Registration District No. **218**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis Childrens Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Illinois** (b) County **Macoupin**
(c) City or town **Staunton**
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country **91**

3. (a) PRINT FULL NAME **Sheryl Wilene Simons**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **none**

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife If alive _____ years

7. Birth date of deceased **February 10 1943**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 1 21 hr. min.

9. Birthplace **Staunton Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name **William Simons**

13. Birthplace **Illinois**
(City, town, or county) (State or foreign country)

14. Maiden name **Eileen Herbeck**

15. Birthplace **Illinois**
(City, town, or county) (State or foreign country)

16. (a) Informant **William Simons**

(b) Address **Staunton, Ill.**

17. (a) **Removal** (Burial, cremation, or removal) (b) Date thereof **4/2/43**
(Month) (Day) (Year)

(c) Place, burial or cremation **Staunton, Ill.**

18. (a) Signature of funeral director **Albert H. Hoppe Inc.**

(b) Address **4700 Washington Blvd.**

19. (a) **4/2/43** (Date received local registrar) (b) **J. F. Bruesch** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **4** day **1**
year **43** hour **2** minute **10** P.M.

21. I hereby certify that I attended the deceased from **3**
20, 19**43** to **4-1**, 19**43**;
that I last saw her alive on **4-1-**, 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Tuberculosis meningitis **3 weeks**

Due to _____

Due to **14** _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy **as above**

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) _____
- (b) Date of occurrence _____
- (c) Where did injury occur? _____ (City or town) (County) (State)
- (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **J. F. Barnett** (M. D. or other) _____
Address _____ Date signed _____

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

J. W. Wilkinson
.....
Licensed Embalmer No. 3578

P. O. Address.....

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.