

FILED DEC 12 1945
Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Barne's Hospital, St. Louis, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **One Month 9 days**
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME **Cheryl Jayne Wiruth**
3. (b) If veteran, name war..... (c) Social Security No.

4. Sex **Female** / 5. Color or race **White** 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 **October 15 1945**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 17 hr. min.

9. Birthplace **East St. Louis, Ill.**
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name **Fred Wiruth**

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

14. Maiden name **Glenna Moody Norton, Kansas**
(City, town, or county) (State or foreign country)

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

16. (a) Informant **Fred Wiruth**

(b) Address **Millstadt, Ill**

17. (a) **Burial** (b) Date thereof **Dec. 5, 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Norton, Kansas**

18. (a) Signature of funeral director **Irving Metzger**
(b) Address **Millstadt, Ill.**

19. (a) **DEC 3 1945** (b) Registrar's signature **J. F. Bredbeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Illinois** (b) County **999**
(c) City or town **Millstadt**
(If outside city or town limits, write "RURAL") **NR**
(d) Street No..... (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No) **Yes**
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **12** day **2**
year **45** hour **2** minute **PM**

21. I hereby certify that I attended the deceased from **10 - 23** 19**45** to **12 - 2** 19**45**
that I last saw her alive on **12 - 2** 19**45**
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Diarrhea of unknown etiology **2** **late**

Due to.....
11/17

Other conditions **Polycystic Kidney; Imperforate anus**
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

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: **R. J. B. C. H. H. H.** (M. D. or other).....
Address **for the Registrar** Date signed.....

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

WRITE PLAINLY—USE 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.....

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

Signed Philip L Metzger

Licensed Embalmer No. 2676

P. O. Address Milledale, Ill.

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.