

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

FILED MAR 26 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10817

State File No. ....

BIRTH NO. 49-119779 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1002 Registrar's No. 2393

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Illinois</u> b. COUNTY <u>9951</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis Missouri</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Collinsville</u> <u>2 1/2</u>	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) <u>204 1/2 Combs</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Berth Memorial 0</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>SHERYL</u> b. (Middle) <u>ANN</u> c. (Last) <u>Whitchurch</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>3-16-49</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>0</u>	8. DATE OF BIRTH <u>3-13-49</u>
9. AGE (In years last birthday) <u>3</u> if UNDER 1 YEAR: Days <u>3</u> if UNDER 24 HRS. Hours <u>16</u> Min. <u>0</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. <u>0</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>0</u>	
11. BIRTHPLACE (State or foreign country) <u>0</u>		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <u>Melvin G. Whitchurch</u>		13b. MOTHER'S MAIDEN NAME <u>Elena P. Kaiser</u>	
14. NAME OF HUSBAND OR WIFE			
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. <u>0</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Elena P. Whitchurch, Collinsville Ill</u>		ADDRESS	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Sepsis Thromb.</u> INTERVAL BETWEEN ONSET AND DEATH <u>70 hrs</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Erythroblastosis fetalis</u> DUE TO (c) <u>16/C</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Prematurity</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>770-0</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-13</u> , 19 <u>49</u> , to <u>3-16</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>3-16</u> , 19 <u>49</u> , and that death occurred at <u>7:42A.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Arthur J. Meagher, M.D.</u> (Degree or title)		23b. ADDRESS <u>3740 Marine Ave.</u>	
23c. DATE SIGNED <u>3-16-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE	
24c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>		24d. LOCATION (City, town, or county) (State) <u>Collinsville Ill</u>	
DATE REC'D BY LOCAL REG. <u>MAR 16 1949</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Geo M. Thompson</u> ADDRESS <u>Collinsville Ill</u>	

**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.

Signed.....

*Geo M. Schroyer*

Signed.....

Student Embalmer

Licensed Embalmer No. *1598*

P. O. Address *Collinsville 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.