U.S. No. 300
REV. 10-48

FILED OCT 18 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34958

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6971

1332

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Louis Childrens Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Illinois
b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): West Frankfort 8120
d. STREET ADDRESS (If rural, give location): 403 W. 6th St.

3. NAME OF DECEASED (Type or Print)
a. (First): Cheryl
b. (Middle): Rae
c. (Last): Johnson

4. DATE OF DEATH (Month) (Day) (Year): August 15, 1950

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: August 10, 1946
9. AGE (In years last birthday): 4 — IF UNDER 1 YEAR: Months / Days — IF UNDER 1 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Centralia, Ill.
12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: Gilbert Johnson
13b. MOTHER'S MAIDEN NAME: Mona Oliver
14. NAME OF HUSBAND OR WIFE: None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Mrs. Mona Johnson, West Frankfort, Ill.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Phosphorous poisoning
ANTECEDENT CAUSES — DUE TO (b): suffered when deceased
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. — DUE TO (c): injected rat paste on rear porch of her home in W. Frankfort Ill
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Aug 11 1950 about 300 pm

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: Accident 812
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): W. Frankfort Ill
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Aug 11 50 300 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: 6889 14

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at 11 55 A m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Patrick E Taylor Cor
23b. ADDRESS: 1300 Clark
23c. DATE SIGNED: 8 16 50

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 8-16-50
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State): West Frankfort, Ill.

DATE REC'D BY LOCAL REG.: AUG 16 1950
REGISTRAR'S SIGNATURE: J. B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Albert H. Hoppe, 4700 Washington Blvd.

(Licensed Embalmer's Statement on Reverse Side)

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~~ me

.....,

working under my personal supervision.

Student Embalmer No.....

Signed [illegible]

Signed.....
Student Embalmer

Licensed Embalmer No. 4699

P. O. Address [illegible]

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.