

FILED FEB 7 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3005

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State File No.

Registrar's No. 538

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. 538	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY St. Louis			
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN Ferguson Mo.		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION De. Paul Hospt				e. STREET ADDRESS (If rural, give location) 511 Plantmore Pl. St. Louis 21			
3. NAME OF DECEASED (Type or Print) a. (First) Harry		b. (Middle) _____		c. (Last) Sherfy		4. DATE OF DEATH (Month) (Day) (Year) 1 15 56	
5. SEX M		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Jan. 6 1926	
9. AGE (In years last birthday) 30		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		11. BIRTHPLACE (City and State or Foreign Country) Richland Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Harry Sherfy		13b. MOTHER'S MAIDEN NAME Beulah York		14. NAME OF HUSBAND OR WIFE Virginia Sherfy			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Virginia Sherfy 511 Plantmore Pl. 21			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure As the Insufficiency & Stenosis DUE TO (b) Rheumatic Heart Disease DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS 12 YRS.? " "	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION 411X 416*				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) _____	
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 11/19 1955 to 1/15 1956, that I last saw the deceased alive on 1/15 1956 and that death occurred at 4:25 p.m., from the causes and on the date stated above.							
23a. SIGNATURE Robert A. Bauer M.D. (Degree or title)				23b. ADDRESS 3731 Goodfellow		23c. DATE SIGNED 1/16/56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1/18/56		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Mo.	
DATE REC'D BY LOCAL REG. JAN 16 1956		REGISTRAR'S SIGNATURE Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Robert D. Kineavy		ADDRESS 2228 St. Louis	

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Stanley H. Wilson*.....

Licensed Embalmer No. *411*.....

P. O. Address *H. L.*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.