

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED FEB 4 1958

State File No. **47571**  
Registrar's No. **12577**

|   |                           |   |   |  |  |  |  |
|---|---------------------------|---|---|--|--|--|--|
| BIRTH NO. _____   |                           | REG. DIST. NO. <b>318</b>   |   | PRIMARY REG. DIST. NO. <b>1003</b>   |  | Registrar's No. <b>12577</b>   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>ST. LOUIS</b>   |                           |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>ST. LOUIS</b> |  |  |  |
| b. CITY (if outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS</b>   |                           | c. LENGTH OF STAY (in this place) <b>4 DAYS</b>   |   | c. CITY OR TOWN <b>FLORISSANT</b>  |  | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> |  |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CHILDREN'S HOSP.</b>  |                           |   |   | e. STREET ADDRESS (If rural, give location) <b>27 48 MARQUETTE DR.</b>   |  |  |  |
| 3. NAME OF DECEASED (Type or Print) a. (First) <b>CHERYL</b> b. (Middle) <b>LOUISE</b> c. (Last) <b>HOWARD</b>  |                           |   | 4. DATE OF DEATH (Month) (Day) (Year) <b>12-27-57</b>       |  |  |  |  |
| 5. SEX <b>F</b>   | 6. COLOR OR RACE <b>W</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>NEVER MARRIED</b>   |   | 8. DATE OF BIRTH <b>9-22-52</b>  |  | 9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 4 HRS. Hours Min. <b>5</b>                        |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>   |   | 11. BIRTHPLACE (City and State or Foreign Country) <b>ST. LOUIS, MO.</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |
| 13a. FATHER'S NAME <b>THOMAS LLOYD HOWARD</b>   |                           |   | 13b. MOTHER'S MAIDEN NAME <b>LOUISE KLEIN</b>               |  | 14. NAME OF HUSBAND OR WIFE <b>NEVER MARRIED</b>                           |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>   |                           | 16. SOCIAL SECURITY NO. <b>NONE</b>   |   | 17. INFORMANT'S SIGNATURE OR NAME <b>Dr. Leib</b> ADDRESS _____  |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Massive gastrointestinal hemorrhage</b><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Acute (lymphocytic) leukemia</b><br><br>DUE TO (c) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>204.0</b> |   |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>   |  |
| 19a. DATE OF OPERATION _____  |                           | 19b. MAJOR FINDINGS OF OPERATION _____  |   |  |  | 20. AUTOPSY? YES <input checked="" 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) (Min.) _____  |                           | 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 <b>Feb.</b> , 19 <b>57</b> , to <b>Dec.</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>12/27</b> , 19 <b>57</b> , and that death occurred at <b>11:30</b> m., from the causes and on the date stated above. |                           |   |   |  |  |  |  |
| 23a. SIGNATURE (Degree or title) <b>Dr. Leib</b>  |                           |   |   | 23b. ADDRESS <b>500 So. Kingshighway</b>   |  | 23c. DATE SIGNED <b>12/27/57</b>   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>  |                           | 24b. DATE <b>12/30/57</b>   | 24c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b> |  | 24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b> |  |  |
| DATE REC'D BY LOCAL REG. <b>DEC 30 57</b>   |                           | REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b>  |   | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Drehmann-Harral 1905 Union Blvd.</b>   |  |  |  |

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 *Albert R. Thompson*.....

Licensed Embalmer No. *4257*.....

P. O. Address *H. J. Davis*.....

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.