

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-027101

STATE FILE NUMBER

FILED JUL 18 1958

Registration District No.

318

Primary Registration District

1003

Registrar's No.

6857

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 39 Cardinal Glennon Hosp.			Length of stay in 1b	d. STREET ADDRESS 239 2736 Park Ave.			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SHERRY LYNN JOHNSON				First	Middle	Last	4. DATE OF DEATH Month Day Year 7-5-58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-5-56		9. AGE (In years last birthday) 1	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Phoenix, Arizona		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Earl E. Johnson				14. MOTHER'S MAIDEN NAME Martha L. Hammontree				
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 Address Martha L. Johnson, 2736 Park Ave.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Encephalitis</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>cause unknown</i> DUE TO (c) <i>343x</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -								INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
MEDICAL CERTIFICATION	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -					
	20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.							
	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE			
21. I attended the deceased from <i>7-4-58</i> to <i>7-5-58</i> and last saw her alive on <i>7-5-58</i> Death occurred at <i>4:30 a.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <i>Clifton P. Lynfowler M.D.</i>				22b. ADDRESS <i>3209 S. Grand</i>			22c. DATE SIGNED <i>7-6-58</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE <i>7-11-1958</i>	23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.			
24. FUNERAL DIRECTOR ADDRESS McLAUGHLIN'S, 2301 Lafayette Ave.				25. DATE RECD. BY LOCAL REG. <i>JUL 9 58</i>		26. REGISTRAR'S SIGNATURE <i>Paul Smith MD</i>		

Health, Welfare, Public Service  
300  
1-56  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.....  
*H. G. Farris*

Licensed Embalmer No. *338*

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.