

FILED SEP 2 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28033

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. **1003** Registrar's No. **7467**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Marion	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Salem	
c. LENGTH OF STAY (in this place) 2 mos - 9 das		d. STREET ADDRESS (If rural, give location) W-11-So. College Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Children's H			

3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
a. (First) Cheryl	b. (Middle) Ann	c. (Last) Fearing	(Month) (Day) (Year) 8-27-49
5. SEX female	6. COLOR OR RACE wh.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) (miser)	8. DATE OF BIRTH 7-5-44
9. AGE (In years last birthday) 5 yrs. 1 22		10. KIND OF BUSINESS OR INDUSTRY (miser)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (miser)		11. BIRTHPLACE (State or foreign country) Salem, Del!	
12. CITIZEN OF WHAT COUNTRY?			

13a. FATHER'S NAME Howard C. Fearing		13b. MOTHER'S MAIDEN NAME Helen Webb		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) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME E. Kunder	
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, assthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Coarctation of aorta. Endocarditis, chronic, mitral valve.		ADDRESS 500 So. Kingshighway	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.			

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) 1578	
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? 4/23/49	

22. I hereby certify that I attended the deceased from **June 18, 1949**, to **Aug. 24, 1949**, that I last saw the deceased alive on **Aug. 27th, 1949** and that death occurred at **2:49 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE Wm. G. Klingberg M.D.		23b. ADDRESS St. Louis Childrens Hosp.		23c. DATE SIGNED 8-27-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 8-27-49		24c. NAME OF CEMETERY OR CREMATORY Salem, Illinois	
24d. LOCATION (City, town, or county) (State) Salem, Illinois		24e. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe Inc.		ADDRESS 4700 Washington	

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE AUG 28 1949 J. B. Bosater		25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe Inc.		ADDRESS 4700 Washington	
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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
Student Embalmer

Signed

Robert M Murray

Licensed Embalmer No. *3749*

P. O. Address *St. Louis*

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.