

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

**1. PLACE OF DEATH**

County..... Registration District No. 791  
 Township..... Primary Registration District No. 1003  
 City St. Louis (No. 4214 W. Finney)  
 Registered No. 9463  
 St. \_\_\_\_\_ Ward)

**2. FULL NAME**

(a) Residence. No. 4214 W. Finney 11 Ward.  
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE Caucasian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Not known

7. AGE 38 YEARS MONTHS \_\_\_\_\_ DAYS \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. OCCUPATION OF DECEASED Laundress  
 (a) Trade, profession, or particular kind of work.  
 (b) General nature of industry, business, or establishment in which employed (or employer) ( )  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Terre Haute  
 (STATE OR COUNTRY)

PARENTS  
 10. NAME OF FATHER William Shepard  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY)  
 12. MAIDEN NAME OF MOTHER Rachel Fisher  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY)

14. INFORMANT George Shepard  
 (Address) 1012 N. Kerolton

15. FILED 19 May 1930 REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-27-1930

17. I HEREBY CERTIFY, That I attended deceased from SEP/27, 1930 SEP/27, 1930 that I last saw her alive on SEP/27/30, 1930, and that death occurred, on the date stated above, at 5:30 p.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
RUPTURED APPENDIX 121 A  
121 B  
 (duration) yrs. mos. 1/12 ds.

CONTRIBUTORY APPENDICITIS (SECONDARY) 2  
 (duration) yrs. mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED HWA  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? NO DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? NO  
 WHAT TEST CONFIRMED DIAGNOSIS \_\_\_\_\_  
 (Signed) M. Moore M. D.  
9/29/30 (Address) 1336 FRANKLIN

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St. Peters DATE OF BURIAL 10-4 1930

20. UNDERTAKER W. S. Wade ADDRESS 4202 Finney

