

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

APR 25 1934

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **781**
Primary Registration District No. **1003**

File No. **11307**
Registered No. **3209**
Ward.....

2. FULL NAME

19473 Betty Deane Shepherd

(a) Residence, No. **6416 N. Broadway** Ward.....

Length of residence in city or town where death occurred **0** yrs. **1** mos. **9** ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Single**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Feb 20 - 1934**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. **0 1 9**

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **none**

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis Mo**

13. NAME **Char Shepherd**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis Mo**

15. MAIDEN NAME **Bessie Parker**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis Mo**

17. INFORMANT (ADDRESS) **Worshipful M. Kent City St. Louis**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Foley Mo** DATE **March 31 1934**

19. UNDERTAKER (ADDRESS) **Shepard Funeral Home Hamilton Ave.**

20. FILED **30 1934** **J. Brebeck** Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **3/29 1934**

22. I HEREBY CERTIFY, That I attended deceased from **2/20 1934** to **3/29 1934**

I last saw her alive on **3/29 1934** Death is said

to have occurred on the date stated above, at **3:15** m.

The principal cause of death and related causes of importance were as follows:

Hard Lip & cleft Palate Date of onset **Birth**

1198

1078

1570

Other contributory causes of importance:

Bronchopneumonia **3/20**

Gastro-intestine **3/1**

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy? **no**

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? If so, specify **St. J. Quattrough** M. D.

(Signed) **St. J. Quattrough** (Address) **City Mo**

11.0

11.0

11.0