

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

Do not use this space.

15284

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Tran Primary Registration District No. 1002
City Kansas City (No. 22 C Gen. Hosp)

File No. _____
Registered No. 2001
St. _____ Ward _____

2. FULL NAME

Charles Shepard
(a) Residence, No. 118 1/2 Indep Ave Ward _____
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Divorced

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 26 1889

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>46</u>	<u>4</u>	<u>15</u>	

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) Nebr.

13. NAME Chas. Shepard

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Nebr.

15. MAIDEN NAME May Ong

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pa

17. INFORMANT (ADDRESS) Reverend Clerk R. C. Gen. Hosp

18. BURIAL, CREMATION, OR REMOVAL PLACE Greenlawn DATE 4/14/36

19. UNDERTAKER (ADDRESS) Peter B. Lopez R. C. Hosp

20. FILED Apr 4 1936 M. M. Brown Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-11 1936

22. I HEREBY CERTIFY, That I attended deceased from 4-11, 1936 to 4-11, 1936

I last saw him alive on 4-11, 1936 Death is said to have occurred on the date stated above, at 7:20 AM

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

Lobar Pneumonia
108

Other contributory causes of importance: _____
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

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 _____

(Signed) [Signature] M. D.
(Address) R. C. Gen. Hosp

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.

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