

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 34941

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 3916

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Transoulet
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: KC Gen Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay in hospital or institution 23 days
(Specify whether
In this community 50 years
years, months or days)

3. (a) PRINT FULL NAME Theresa B. Shepherd ¹⁶⁵

3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex F 5. Color or race W. 6. (a) Single, widowed, married, divorced W.

6. (b) Name of husband or wife George Shepherd 6. (c) Age of husband or wife if alive unk years

7. Birth date of deceased Oct 10 1867
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|-----------|-----------|----------------------|
| | <u>21</u> | <u>11</u> | <u>29</u> | hr. _____ min. _____ |

9. Birthplace Logan County Mo
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business _____

12. Name Jacob Bloom

18. Birthplace Ga.
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Bloomer

15. Birthplace Burns Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature John A. Shepherd

(b) Address 2615 Lawton K.C. Mo

17. (a) Burial (b) Date thereof Oct 12 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brookings

18. (a) Signature of funeral director Mrs C. B. Focht

(b) Address 10/10/39 918 Brooklyn

19. (a) 10/10/39 (b) M. W. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Transoulet
(If outside city or town limits, write "RURAL")
(d) Street No. 2615 Lawton
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 9
year 1939 hour 11 minute 40 P. M.

21. I hereby certify that I attended the deceased from 9-16
1939 to 10-9 1939
that I last saw h.s. alive on 10-9 and that death occurred on the date and hour stated above.

Immediate cause of death Primary carcinoma of recto sigmoid colon with metastasis to liver Duration _____
Due to hypostatic pneumonia

Due to intracapsular fracture of left femur

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence about Aug 10th 1939

(c) Where did injury occur? at home
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? at home

While at work? _____ (Specify type of place)

(e) Means of injury fall

23. Signature J. De Mama M.D. (M.D. or other) _____

Address Supt KC Gen Hosp Date signed 10/10/39

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

1 X19311

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *Theron A. Bedner*

Licensed Embalmer No. 2737

P. O. Address K. C. Mo.

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, above space should be left blank.