

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.

APR 1 1940
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8702
Registrar's No. 2185

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County Mo.
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2819 Stoddard St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 21
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2819 Stoddard St
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

In this community _____ years, months or days
3. (a) PRINT FULL NAME Sarah Jane Shepherd
3. (b) If veteran, name war no
3. (c) Social Security No. no

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month MAR, day 3
year 1940 hour 8 minute 20 P. M.
21. I hereby certify that I attended the deceased from Jan. 4
_____, 1940, to March 3, 1940,
that I last saw her alive on March 3, 1940,
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race col
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Thomas Shepherd
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased sep 13 1869
(Month) (Day) (Year)

Immediate cause of death _____
chron. Myo-Carditis
Due to Idiopathic
Due to _____
Other conditions _____
(Include pregnancy within 5 months of death)
Major findings: _____
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

8. AGE: Years 70 Months 05 Days 19
If less than one day _____ hr. _____ min.

9. Birthplace Dixon Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Landress

11. Industry or business _____
12. Name John Ashby
18. Birthplace unknown
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth
15. Birthplace unknown
(City, town, or county) (State or foreign country)

18. (a) Informant's own signature J. F. Walcott
(b) Address 2819 Stoddard St

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

17. (a) _____ (b) Date thereof 3 8 40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Greenwood Cem

While at work? _____ (Specify type of place) (a) Means of injury _____
23. Signature J. F. Walcott M.P. (M. D. or other)
Address 1001 N. Jefferson Date signed 3-4-40

18. (a) Signature of funeral director A. F. Walton
(b) Address 2707 Stoddard St
19. (a) MAR 4 1940 (b) J. F. Walcott
(Date received local registrar) (Signature of Registrar)

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.....

William C. McDowell, Registered Apprentice No.....
working under my personal supervision.

Signed William C. McDowell

Licensed Embalmer No. 2114

P. O. Address.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8702

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registrar's No. 2185

Registration District No. 791

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2819 Stoddard
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME Sarah Jane Shepherd
(b) If veteran, name war.....
3. (c) Social Security No.....

4. Sex 7 5. Color or race col 6. (a) Single, widowed, married, divorced wid
(b) Name of husband or wife Thomas J. Shepherd (c) Age of husband, or wife, if alive.....
7. Birth date of deceased.....
(Month) (Day) (Year)

8. AGE: Years 70 Months 5 Days 19 If less than one day.....
min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....
13. Birthplace.....
(City, town, or county) (State or foreign country)
14. Maiden name.....
15. Birthplace.....
(City, town, or county) (State or foreign country)

16. (a) Informant.....
(b) Address.....

17. (a) (Burial, cremation, or removal) (b) Date thereof.....
(Month) (Day) (Year)
(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
(b) Address.....
19. (a) 5-7-40 (b) J. B. Redbeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month mar day 3
year 1940 hour..... minute..... M.
21. I hereby certify that I attended the deceased from.....
....., 19....., to....., 19.....;
that I last saw him..... alive on....., 19.....;
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Duration

Due to.....
Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
.....

While at work..... (Specify type of place)
(e) Means of injury.....

23. Signature J. B. Redbeck (M. D. or other)
Address 1001 N. Jefferson Date signed.....

SUPPLEMENTARY

