

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.

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

Do not use this space.

FILED JUN 20 1940

18298

**1. PLACE OF DEATH**

County De Kalb Registration District No. 25-85-36 File No. \_\_\_\_\_  
 Township Washington 2 Primary Registration District No. 470-27 Registered No. 7  
 City Stewartville (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

John W. Shepherd  
 (a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode)

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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2-25-1878

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>62</u>	<u>2</u>	<u>11</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer

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) 1-2-0-1939 11. Total time (years) spent in this occupation 37

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Madison Co. Mo.

13. NAME William Shepherd

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

15. MAIDEN NAME Nancy Hainley

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

17. INFORMANT (ADDRESS) Mrs. John Shepherd

18. BURIAL, CREMATION, OR REMOVAL PLACE Whiteville DATE 5-8-1940

19. UNDERTAKER (ADDRESS) John P. Brown

20. FILED May 8, 1940 Mrs. C. M. Davis Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 6<sup>th</sup>, 1940

22. I HEREBY CERTIFY, That I attended deceased from Mar 15, 1940 to May 6<sup>th</sup>, 1940  
 last saw him alive on May 5<sup>th</sup>, 1940. Death is said to have occurred on the date stated above, at 8:30 p. m.  
 The principal cause of death and related causes of importance were as follows:

Carcinoma of Stomach & Colon Date of onset \_\_\_\_\_

Other contributory causes of importance: \_\_\_\_\_

Name of operation Y Date of \_\_\_\_\_  
 What test confirmed diagnosis? X-ray Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? Y Date of injury 7, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. X

Manner of injury Y  
 Nature of injury X

24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify \_\_\_\_\_  
 (Signed) D. E. Saunders, M. D.  
 (Address) Stewartville Mo

7/6

RECEIVED

District Health Officer No. 111

District File Number ~~648-856~~

Date Filed ~~JUN 10 1948~~

THE CIVIL RIGHTS DIVISION OF THE U.S. DEPARTMENT OF JUSTICE

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 18298  
Registrar's No. \_\_\_\_\_

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 258

Primary Registration District No. 5360A

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

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME John W Shepherd  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year \_\_\_\_\_

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 62 Months 2 Days 11 If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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) (Date received local registrar) (b) (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 May day 6 year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Stomach & Bowels Duration 9

Due to #76 M.D. Physician

Due to died - 9-10-40

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 46 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 \_\_\_\_\_ (M. D. or other) Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTAL

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