

Registration District No. 824 Primary Registration District No. 6076 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH

(a) County Shannon  
(b) City or town Emmises  
(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) 20  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Carol Shppard

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

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

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

7. Birth date of deceased Nov - 3 - 1946  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 5 hr. \_\_\_\_\_ min.

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

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

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

MOTHER FATHER { 12. Name James Carlos Shppard 0

13. Birthplace Louisville Miss  
(City, town, or county) (State or foreign country)

14. Maiden name Pauline Hillman

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

16. (a) Informant P. Hillman

(b) Address Emmises Mo

17. (a) Burial (b) Date thereof 11-3-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Emmises Mo

18. (a) Signature of funeral director none 11/11

(b) Address \_\_\_\_\_

19. (a) 11-3-40 (b) Frank Hyde  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shannon  
(c) City or town Emmises  
(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 Nov day 3  
year 1940 hour 5 minute 0 M.

21. I hereby certify that I attended the deceased from Nov 3-46  
Nov - 3 - 1940, to 1946;  
that I last saw her alive on Nov - 3 - 1940;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Premature Birth

Due to \_\_\_\_\_

Due to \_\_\_\_\_ 154

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 \_\_\_\_\_

(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 Frank Hyde (M. D. or other) 1

Address Emmises Date signed 11-3-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 5,

District File Number 1190149

Date Filed \_\_\_\_\_

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**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

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.