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S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

FILED FEB 23 1943

Registration District No. 318

Primary Registration District No. 1003

State File No. 4764

Registrar's No. 1442

**1. PLACE OF DEATH:**

(a) County

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis City Hospital #1 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 Days (Specify whether
In this community years, months or days)

**2. USUAL RESIDENCE OF DECEASED:** 000

(a) State Mo. (b) County 17

(c) City or town St. Louis 9 6
(If outside city or town limits, write "RURAL")

(d) Street No. 5835A Theodisa Ave.,
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME James Thomas Sheppard

3. (b) If veteran, name war No

3. (c) Social Security No. 304-12-6575

4. Sex Male

5. Color or race White 0

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Sept. 10, 1910.
(Month) (Day) (Year)

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 32 | 5 | 3 | hr. min. |

9. Birthplace Illinois 1
(City, town, or county) (State or foreign country)

10. Usual occupation Filling Station Operator

11. Industry or business

FATHER
12. Name Rogers Shepard
13. Birthplace Don't Know 9
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Rose Kincade 9
15. Birthplace Don't Know
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Rose Shepard
(b) Address 5835A Theodisa Ave.,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 15/43
(Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park Cem.,

18. (a) Signature of funeral director Jos. W. Clark
(b) Address FEB 1125 Hodiamont Ave.,

19. (a) FEB 14 1943 (Date received local registrar) (b) J. J. Budeck (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month February day 13,
year 1943 hour 6:25 minute A.M.

21. I hereby certify that I attended the deceased from February 8, 1943, to February 13, 1943;
that I last saw him alive on February 13, 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death Rheumatic heart disease c mitral stenosis

Due to

Due to 9 2

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy as above

Duration

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature Drew on Petersen 0 (M. D. or other)

Address 1515 Lafayette Avenue, Date 2/13/43

(Licensed Embalmer's Statement on Reverse Side)

## 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. 3225

P. O. Address 1125 Hodiamont Ave.

**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, fact should be so stated above.**