

FILED MAR 11 1949  
Registration District No. \_\_\_\_\_

Primary Registration District No. 106

Registrar's No. 416

1. PLACE OF DEATH:  
(a) County St Louis  
(b) City or town St. Kirkwood  
(c) Name of hospital or institution: 200 Saratoga 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 yrs. (Specify whether years, months or days)  
In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME William C. SHEPPERD Sr.  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. none

4. Sex male 5. Color of race Cal 6. (a) Single, widowed, married  
6. (b) Name of husband or wife Jane 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased May 27 1868  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>8</u>	<u>21</u>	_____ hr. _____ min.

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

10. Usual occupation nil

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

12. Name Unknown  
13. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Olava Shepard  
15. Birthplace ? No. Carolina  
(City, town, or county) (State or foreign country)

16. (a) Informant Wm. Shepperd  
(b) Address 200 Saratoga  
17. (a) Burial (Burial, cremation or removal) (b) Date thereof 2-20-43  
(Month) (Day) (Year)  
(c) Place: burial or cremation Catawissa, Mo

18. (a) Signature of funeral director Blater & Sons  
(b) Address Kirkwood, Mo.  
19. (c) FEB 19 1949 (Date recorded) (Registrar) (d) C. H. McTearon M.D. (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County St Louis  
(c) City or town St. Kirkwood  
(If outside city or town limits, write "RURAL.")  
(d) Street No. 200 Saratoga  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 17  
year 1943 hour 4:15 minute \_\_\_\_\_ A. M.  
21. I hereby certify that I attended the deceased from July 15  
1942 to Feb 17 19 43  
that I last saw him alive on Feb 16 19 43  
and that death occurred on the date and hour stated above.

Immediate cause of death Infirmities of age Duration 7 mo.  
Due to Infirmities of age  
Due to \_\_\_\_\_  
Other conditions none  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: none  
Of operations none  
Of autopsy none  
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) no  
(b) Date of occurrence none  
(c) Where did injury occur? no injury  
(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 W. B. D. Dancy (M.D. or other)  
Address W. B. D. Dancy Date signed 2/19/43

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

96  
4  
3

MOTHER FATHER

**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.....

*Ronald V. Adams*

Licensed Embalmer No.....

*2842*

P. O. Address.....

*3644 Finney Ln*

**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.**