

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

AUG 9 1943 41

Registration District No. _____

Primary Registration District No. 3025

Registrar's No. 78

1. PLACE OF DEATH:

(a) County HOWELL

(b) City or town WEST PLAINS
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
WEST PLAINS HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 WEEKS
(Specify whether _____)

In this community 43 YEARS
years, months or days

2. USUAL RESIDENCE OF DECEASED: 16

(a) State MISSOURI (b) County HOWELL

(c) City or town WEST PLAINS
(If outside city or town limits, write "RURAL")

(d) Street No. 116 So. MAIN
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME LAURA HOMRIGHAUSEN SHEPARD

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 23,
year 1943 hour 2 minute 20 P.M.

4. Sex FEMALE

5. Color or race WHITE

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

6. (b) Name of husband or wife JERIMIAH A. SHEPARD

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

7. Birth date of deceased JAN. 16, 1879
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June, 1937, to May 23, 1943, that I last saw her alive on May 23, 1943 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

64 4 7 hr. min.

Immediate cause of death acute cardiac
celestialis

Due to Chr myocarditis

Due to angina pectoris
mitral Regurgitation

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

Duration 6 days

MOTHER FATHER

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

10. Usual occupation NURSE

11. Industry or business Hospital

12. Name LEWIS H. HOMRIGHAUSEN

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

14. Maiden name LOUISE SHERER

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

Major findings: Of operations X

Of autopsy X

93d

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. CHAS. SMITH

(b) Address WEST PLAINS, Mo.

17. (a) BURIAL (b) Date thereof MAY 25, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation OAK LAWN CEM. WEST PLAINS, Mo.

18. (a) Signature of funeral director Hal Thompson

(b) Address WEST PLAINS, Mo.

19. (a) 7 Oct 43 (b) Judy V. [Signature]
(Date received local registrar) (Registrar's signature)

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? X (Specify type of place)

Means of injury _____

Signature Manuel Thompson (M. D. or other) _____

Address West Plains, Mo. Date signed 5/24/43

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

RECEIVED

District Health Officer No. 5,

District File Number 843475-

Date Filed 8-6-43

APR 1 1946

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 Hal Thomburgh.....

Licensed Embalmer No. 3408.....

P. O. Address West Plains, Mo......

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.