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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

S. No. 2
M-2-43
5-17-39
I X35897

FILED OCT 13 1943

Registration District No. 1002

Primary Registration District No. 1002

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution General Hospital No. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 90 days
(Specify whether years, months or days)

In this community 3 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 3848 Olive St.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MOZELLE SHEPHARD

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female 5. Color or Race Negro 6. (a) Single, widowed, married, divorced, single

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

7. Birth date of deceased September 28, 1917
(Month) (Day) (Year)

8. AGE: Years 25 Months 11 Days 20 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housework

11. Industry or business _____

MOTHER FATHER { 12. Name Lawrence Shephard

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

14. Maiden name Carrie Hunter

15. Birthplace Wichita Falls, Texas
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk

(b) Address General Hospital No. 2

17. (a) burial (b) Date thereof 9/23/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cemetery

18. (a) Signature of funeral director Hatkins Bros

(b) Address 1729 Lydia

19. (a) 9-23-43 (b) T. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9- day 18
year 1943 hour 10:30 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from 4-17-43
19____ to 9-18, 1943
that I last saw her alive on 9-18-43, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Insanition (cachexia)

Due to Pulmonary Tuberculosis

Due to 135'

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

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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) Means of injury _____

23. Signature B. O. Turner (M. D. or other) M.D.

Address General Hosp. No. 2 Date signed 9-21-43

(Licensed Embalmer's Statement on Reverse Side)

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

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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 James Mullove
Licensed Embalmer No. 3994
P. O. Address. 2503 Highland

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.