

FILED MAY 2 1944
Registration District No. **550**

Primary Registration District No. **5572**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Rural Prairie Twp**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Jackson County E. Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **67 days**
In this community **50 yrs.**
years, months or days) **Hickman mills** (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Hickman Mills, 47**
(If outside city or town limits, write "RURAL")
(d) Street No. **103 Raytown Road**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **O**

3. (a) PRINT FULL NAME **William O. Sheppard**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **none**

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Daisy Sheppard**
6. (c) Age of husband or wife if alive **73** years
7. Birth date of deceased **March 15 1875**
(Month) (Day) (Year)

8. AGE: Years **69** Months **0** Days **5** If less than one day hr. min.

9. Birthplace **Penn.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Blacksmith**

11. Industry or business **For self**

12. Name **Walter Sheppard**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Clarence Kelley**

(b) Address **2246 Poplar St. C. Mo.**

17. (a) **Burial** (b) Date thereof **3-22-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Chynwood**

18. (a) Signature of funeral director **Corp F. Home**

(b) Address **Kansas City Mo.**

19. (a) **Mar. 20, 1944** (b) **F. M. Schickel**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **19th**
year **1944** hour **7** minute **50 A.M.**

21. I hereby certify that I attended the deceased from **1-12 1944** to **3-19 1944**
that I last saw him alive on **3-17 1944**
and that death occurred on the date and hour stated above.

Immediate cause of death: **epilepsy**
Spontaneous Myocardial
Due to **epilepsy**
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

Duration **3-4 Mo**
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? _____
While at work? (Specify type of place) _____
(e) Means of injury _____

23. Signature **[Signature]** (M. D. or other) **[Signature]**
Address **[Address]** Date signed **3/20/44**

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

MOTHER FATHER

1162

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 John B. Corp.

Licensed Embalmer No. 2953

P. O. Address K. C. 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. May
Registrar's No. 328

Registration District No. 150

Primary Registration District No. 5572

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Rural Prairie Twp
(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)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days)

3. (a) PRINT FULL NAME Wm O. Sheppard

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

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

7. Birth date of deceased March 15 1881
(Month) (Day) (Year)

8. AGE: Years 69 Months 0 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19
year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to Chronic nephritis 24 yrs

Due to _____

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) (c) Means of injury _____

23. Signature Wm O. Sheppard (M. D. or other) Med

Address 255 S. 1st St Date signed 5-4-44

SUPPLEMENTAL

PHYSICIAN

Duration
24 yrs
Underline the cause to which death should be charged statistically.

14846