

S. No. 2
FORM-8-43
Rev. 5-17-39
X37823

25383

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS
FILED AUG 10 1944

Shipp & Markey
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 72

Registration District No. 270

Primary Registration District No. 3050

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
78,
2

1. PLACE OF DEATH:
(a) County Pemiscot
(b) City or town Caruthersville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
None
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution None (Specify whether
In this community 60 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Pemiscot 78
(c) City or town Caruthersville 1
(If outside city or town limits, write "RURAL") 2
(d) Street No. 304 E. 3rd St.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country Citizen of U.S.A. 0

3. (a) PRINT FULL NAME Charles Grant Shepard
(b) If veteran, name war NO
(c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 6
year 1944 hour 6 minute 00P. a.m.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
(b) Name of husband or wife Amanda Shepard
(c) Age of husband or wife if alive 61 years
7. Birth date of deceased October 18, 1862
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from
December 19, 1944 to July 6, 1944
that I last saw him alive on July 6, 1944
and that death occurred on the date and hour stated above.

8. AGE: Years 81 Months 8 Days 18
If less than one day
hr. _____ min. _____

Immediate cause of death Cerebral hemorrhage.
Due to Hypertention.

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

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

10. Usual occupation Lawyer
11. Industry or business Same

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

MOTHER FATHER
12. Name John S. Shepard
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Griffith
15. Birthplace Tennessee
(City, town, or county) (State or foreign country)

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? _____

16. (a) Informant Mrs. C. G. Shepard
(b) Address Caruthersville, Mo.
17. (a) Burial (b) Date thereof 7-8-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Caruthersville, Mo.

While at work? _____ (Specify type of place) _____
(c) Means of injury _____
23. Signature J. W. Shipp (M. D. or other) _____
Address Caruthersville Mo. Date signed 7/19/44

18. (a) Signature of funeral director J. L. Du Jauge
(b) Address Caruthersville, Mo.
19. (a) 7-9-1944 (b) Jesse H. Markey
(Date of local registrar) (Registrar's signature)

7-44-179

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

Jack Kelley

Licensed Embalmer No.

3788

P. O. Address

Hayt. 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.