

FILED AUG 29 1944

State File No.

Registration District No.

Primary Registration District No.

6054

Registrar's No.

16

1. PLACE OF DEATH:

(a) County St. Clair
(b) City or town Rural Osage
(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 2 1/2 yrs
years, months or days

3. (a) PRINT FULL NAME GEORGE ALVIN SHEPARD

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Hester V. Cunningham 6. (c) Age of husband or wife if alive years

7. Birth date of deceased Feb 23 1955
(Month) (Day) (Year)

8. AGE: Years 88 Months 5 Days 10
If less than one day _____ hr. _____ min.

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

10. Usual occupation

11. Industry or business

12. Name James I. Shepard

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

14. Maiden name Moffitt
15. Birthplace Ohio (City, town, or county) (State or foreign country)

16. (a) Informant Milton Shepard

(b) Address Appleton City, Mo

17. (a) Bury (Burial, cremation, or removal) (b) Date thereof July 16 1944
(Month) (Day) (Year)

(c) Place: burial or cremation Appleton City, Mo

18. (a) Signature of funeral director Frank Lee

(b) Address Appleton City, Mo

19. (a) July 14 1944 (Date received local registrar) (b) Gene M. Bell (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Clair
(c) City or town Rural
(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 July day 13
year 1944 hour 5 minute 20 P. M.

21. I hereby certify that I attended the deceased from Sept 1, 1939 to June 1, 1940
that I last saw him alive on July 1, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Unknown
probably due to
Heart failure

Due to myocarditis
and tubercle

Due to Hypertension
Chronic Nephritis

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 131 P

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?

(Specify type of place) While at work? _____ (e) Means of injury _____

23. Signature R. L. Lanning (M. D. or other) M.D.
Address Appleton City, Mo Date signed 7-14-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

MOTHER FATHER

RECEIVED

District Health Officer No. 7,

District Office Number

Date Filed

7-44-947

8-9-44

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 Me
on the 13th day of July 1944, Registered Apprentice No. _____
working under my personal supervision.

Signed

Frank Lee

Licensed Embalmer No. 1099

P. O. Address Appleton

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete 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. Aug
Registrar's No. 161

Registration District No. 311 Primary Registration District No. 6054

1. PLACE OF DEATH:
(a) County St. Clair
(b) City or town Rural Osage Jct.
(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 George A. Shepard
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 w
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb. 23
(Month) (Day) (Year)

8. AGE: Years 38 Months 5 Days 10 (If less than one day, _____ min.)

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

10. Usual occupation Farmer

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 _____ day _____ year _____ 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 _____
Duration _____
Due to _____
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) (e) Means of injury _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

MOTHER FATHER

TEMPORARY

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

25556