. No. 2
—1-4-41
5-17-39
I X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 24 1944

Registration District No. 1208

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 37811

Primary Registration District No. 2000

Registrar's No. 896

1. PLACE OF DEATH:
(a) County GREENE
(b) City or town SPRINGFIELD
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: O'REILLY GENERAL HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 23 DAYS (Specify whether years, months or days) In this community 23 DAYS

2. USUAL RESIDENCE OF DECEASED:
(a) State CALIFORNIA (b) County LOS ANGELES
(c) City or town LOS ANGELES
(If outside city or town limits, write "RURAL")
(d) Street No. 1570 SOUTH HOBART BLVD.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME FLOYD SHEPHERD
3. (b) If veteran, name war WORLD WAR II
3. (c) Social Security No. UNK.
4. Sex MALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced SINGLE
6. (b) Name of husband or wife NONE
6. (c) Age of husband or wife if alive XX years
7. Birth date of deceased FEB. (Month) 3 (Day) 1906 (Year)

8. AGE: Years 38 Months 9 Days 90 If less than one day hr. min.

9. Birthplace NEWTON (City, town, or county) KANSAS (State or foreign country)
10. Usual occupation LANDSCAPE ARCHITECT
11. Industry or business
FATHER 12. Name CLAYBOURN J. SHEPHERD
13. Birthplace UNK. (City, town, or county) MISSOURI (State or foreign country)
MOTHER 14. Maiden name INEZ CALDWELL
15. Birthplace UNK. (City, town, or county) MISSOURI (State or foreign country)
16. (a) Informant MRS. EVA PATTERSON
(b) Address YATES CENTER, KANSAS
17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 11-13-44 (Month) (Day) (Year)
(c) Place: burial or cremation YATES CENTER, KANSAS
18. (a) Signature of funeral director H. H. Schumpert
(b) Address 458 E. WALNUT, SPRINGFIELD, MO
19. (a) 11-13-44 (Date received local registrar) (b) W. E. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV. day 12 year 1944 hour 11 minute 20 A.M.
21. I hereby certify that I attended the deceased from 21 OCTOBER, 1944, to 12 NOVEMBER, 1944; that I last saw him alive on 12 NOVEMBER, 1944; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death CARDIAC FAILURE	3 hrs
Due to TRANSVERSE MYELITIS.	3 mos. 3 days
HEPATITIS	5 days
Due to RETRO-PERITONEAL ABSCESS	2 mos.
	20 days
Other conditions NONE (Include pregnancy within 3 months of death)	

Major findings: Of operations COMPRESSION OF CORD
Of autopsy 196

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) BATTLE CASUALTY
(b) Date of occurrence 9 AUGUST 1944
(c) Where did injury occur? CAMP DE BOUT, FRANCE (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ON BATTLE FIELD (Specify type of place)
While at work? YES (e) Means of injury SHRAPNEL
23. Signature Robert W. Maher (M. D. or other)
Address ROBERT W. MAHER 1ST LT. MC O'REILLY GEN. HOSP. Date signed 11-12-44

9 x 4

(Licensed Embalmer's Statement on Reverse Side)

ORIGINAL SIGNED REPORT FURNISHED TO THE BUREAU OF CENS

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.....

Licensed Embalmer No. 2457

P. O. Address.....

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.