

FILED JUN 5 1945

Registration District No. 176

Primary Registration District No. 3020

Registrar's No. 51

1. PLACE OF DEATH:

(a) County Franklin
(b) City or town Washington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Francis Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 1 day
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin
(c) City or town Pacific ³¹
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

HIRAM JULES SHEPARD

3. (b) If veteran,

name war No

3. (c) Social Security

No. _____

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife

Jessie Shepard

6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased

Feb. 6 - 1899
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>46</u>	<u>2</u>	<u>25</u>	hr. _____ min.

9. Birthplace

Chicago Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation

Driller

11. Industry or business

Well driller

12. Name

Hiram Shepard

13. Birthplace

Ill.
(City, town, or county) (State or foreign country)

14. Maiden name

Martha

15. Birthplace

Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant

Wm Shepard

(b) Address

Pacific Mo

17. (a) _____

(Burial, cremation, or removal)

(b) Date thereof

5/2/45
(Month) (Day) (Year)

(c) Place: burial or cremation

Pacific Mo

18. (a) Signature of funeral director

John L. Shibe

(b) Address

Pacific Mo

19. (a) 5/2/45

(Date received local registrar)

Laurel R. Brock

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 21

year 1945 hour 12 minute 30 P.M.

21. I hereby certify that I attended the deceased from

April 30, 1945, to May 21, 1945

that I last saw him alive on May 21, 1945
and that death occurred on the date and hour stated above

Immediate cause of death: Compensated, comminuted, depressed skull fracture, contusion of brain with intracranial hemorrhage

Due to: blow on head from falling steel object.

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

Duration

PHYSICIAN

Major findings:

Of operations: as above.

Of autopsy: 115/50

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) accident

(b) Date of occurrence April 30 1945

(c) Where did injury occur? Near Hwy 50 west of Union, Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
farm

While at work? yes (Specify type of place) (e) Means of injury falling steel

23. Signature Paul G. Mass (M. D. or other) MD

Address 3112 1/2th, Washington Date May 1, 45

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

6
6
2

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 6-4-45

JUN 28 1945

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.....

Jno. L. Sheehy

Licensed Embalmer No. 3008

P. O. Address.....

Pacific Sm.

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.