

**FILED** AUG 12 1946

Registration District No. \_\_\_\_\_ Primary Registration District No. 5-27-3-5456 Registrar's No. 5

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Nixa, rural Potter Wicks  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Rt. #1 residence  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

(c) City or town Nixa, rural  
(If outside city or town limits, write "RURAL")

(d) Street No. Route #1  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MRS. LENA L. SHEPARD

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Female / 5. Color or race White

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

6. (b) Name of husband or wife Will E. Shepard

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

7. Birth date of deceased September 18, 1881  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

64 10 12 hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Thomas R. Appleby

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

14. Maiden name Betty Travis

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

16. (a) Informant Will E. Shepard

(b) Address Rt. #1 Nixa, Missouri

17. (a) Burial Green Lawn Cemetery  
(Burial, cremation, or removal)

(b) Date thereof July 2, 1946  
(Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cemetery

18. (a) Signature of funeral director ALMA LOHMEYER FUNERAL HOME

(b) Address 534 St. Louis St. Springfield, Mo

19. (a) July 21, 1946 (b) Ms. Allene Deier  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30  
year 1946 hour 7 minute A. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to 6-30 1946  
that I last saw her alive on 6-28 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Chc. Cholelithiasis 25yr.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 12/70  
(Include pregnancy within 3 months of death)

Major findings: Chc. Cholelithiasis  
(Not removed)

Of autopsy \_\_\_\_\_

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) (c) Means of injury

23. Signature Ms. Deier (M. D. or other) MS  
Address Open St. Springfield, Mo Date signed 7-2-46

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

RECEIVED

District Health Officer No. 6,

District File Number 846-840

Date Filed AUG 8 - 1946

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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 L. A. Paul

Licensed Embalmer No. 3044

P. O. Address Springfield 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.