

FILED JAN 27 1947

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 93

1. PLACE OF DEATH:

(a) County Buchanan  
 (b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
1501 Francis St. (Nursing Home)  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 Yr. Nursing Home  
(Specify whether  
 In this community 40 Years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan  
 (c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 1501 Francis St.  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country. \*

3. (a) PRINT FULL NAME Rose Cora Sheppard

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

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

6. (b) Name of husband or wife Charles 6. (c) Age of husband or wife if alive 20 years 1860

7. Birth date of deceased. August 20 1860  
(Month) (Day) (Year)

8. AGE: Years 86 Months 4 Days 28  
 If less than one day  
 hr. min.

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

10. Usual occupation None

11. Industry or business None

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. J. W. Bradley

(b) Address Kansas City, Missouri

17. (a) Burial (b) Date thereof Jan. 22, 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director Norman W. Sidenfaden  
 (b) Address 1802 Union St. St. Joseph, Mo.

19. (a) 1-22-47 (b) N. C. Jenkins  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 18  
 year 1947 hour 12: minute 50 A. M.

21. I hereby certify that I attended the deceased from July 15  
1946 to Jan 17 1947  
 that I last saw her alive on Jan 17th 1947  
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Mitral Insufficiency 1 year  
Chronic Myo-Carditis 1 year

Due to Chronic Myo-Carditis 1 year  
 Due to  
 Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations:  
 Of autopsy no 92B

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) (e) Means of injury

23. Signature H. F. Mundy (M. D. or other)  
 Address 404 So 3d Date signed 1/21/47

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

MOTHER FATHER

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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 *Hermon W. Siddeford*.....

Licensed Embalmer No. *2728*.....

P. O. Address *St. Joseph 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.**