

FILED OCT 6 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30947

State File No. _____

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 800

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: St Johns Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 6 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene 39
(c) City or town Springfield 2
(If outside city or town limits, write "RURAL")
(d) Street No. 1867 N. Campbell 6
(If rural, give location) 0
(e) Citizen of foreign country? None (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME David Sheppard

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 Widower

6. (b) Name of husband or wife Cynthia Sheppard 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 17, 1859
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>88</u>	<u>3</u>	<u>23</u>	hr. min.

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

10. Usual occupation Retired Grocerman

11. Industry or business Grocer And Meat Market

12. Name Fisher Sheppard

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

14. Maiden name Unknown

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

16. (a) Informant Bass Nelson

(b) Address Detroit, Mich.

17. (c) Burial (b) Date thereof 9/12/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hazelwood Cem.

18. (a) Signature of funeral director Jawlingner & Co.

(b) Address Springfield Mo.

19. (a) 9-11-47 (b) W E Handley MD
(Date received local registrar) (Registrar's signature)

(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September Day 10
Year 1947 hour 7 minute 05 A.M.

21. I hereby certify that I attended the deceased from 9-4-47, 1947 to 9-10, 1947
that I last saw him alive on 9-9-47, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal obstruction

Due to Strangulated Inguinal Hernia 4 days

Other conditions (Include pregnancy within 3 months of death)

Major findings of operation Large benign mass of sigmoid. 12
Of autopsy _____

Duration
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 J. D. Stair (M. D. or other) MD
Address Springfield Mo. Date signed 9/10/47

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

MOTHER FATHER

SEP 3 1958

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

May Rhodes

Licensed Embalmer No. *4071*

P. O. Address *Springfield*

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: