

S. No. 2  
M-1/47  
7-5-17-39

FEDERAL BUREAU OF VITAL STATISTICS

DEPARTMENT OF HEALTH  
STANDARD CERTIFICATE OF DEATH

33345

State File No. \_\_\_\_\_

National Office of Vital Statistics  
**FILED** SEP 29 1947

Registration District No. 31947

Primary Registration District No. 6076

Registrar's No. 1971

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis County, Mo. Baskerville  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution 8445 McKenzie  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis  
(c) City or town St. Louis County, Mo. Baskerville  
(If outside city or town limits, write "RURAL")  
(d) Street No. 8445 McKenzie  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Edward C. Sheppard,  
3. (b) If veteran, No name war \_\_\_\_\_  
3. (c) Social Security No. none

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced 1  
6. (b) Name of husband or wife Ruth  
6. (c) Age of husband or wife if alive 57 years  
7. Birth date of deceased March 14 1890  
(Month) (Day) (Year)

8. AGE: Years 57 Months 5 Days 25  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace St. Louis Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Truck Driver

11. Industry or business \_\_\_\_\_  
12. Name Charles 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 Mrs Ruth Sheppard  
(b) Address 8445 McKenzie  
17. (a) Burial (b) Date there 9/11/47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Our Redeemer Cemetery

18. (a) Signature of funeral director Wm J. J. J. J.  
(b) Address 4016 Chippewa  
19. (a) 9-19-47 (b) W. W. Forman  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 9  
year 1947 hour 7 minute 20 A.M.

21. I hereby certify that I attended the deceased from Aug 17 1947 to 9-9 1947  
that I last saw him alive on 9-8 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis  
Cardiac decompensation  
Due to 9-5-47  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Duration 1 hr  
2 1/2 hrs  
PHYSICIAN \_\_\_\_\_  
Underline the cause of which death should be charged statistically.

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 \_\_\_\_\_  
(Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature W. W. Forman (M. D. or other) MD  
Address 936 Garois Date signed 9-10-47

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

OCT 20 1947

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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 *G. W. Wilkinson*  
Licensed Embalmer No. 3575  
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.