

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

40553

FILED DEC 8 1947
Registration District No. 317

Primary Registration District No. 6076

State File No.
Registrar's No. 2468

1. PLACE OF DEATH:

(a) County. St. Louis
(b) City or town. Ballwin
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Pine Crest Nursing Homes
(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)

3. (a) PRINT FULL NAME Frank Otis Shepard

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan. 12 1855
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
92 10 18 hr. min.

9. Birthplace Hardford Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER { 12. Name David Lindley Shepard
13. Birthplace Westfield, Mass.
(City, town, or county) (State or foreign country)
14. Maiden name Olive Brodckway
15. Birthplace Hardford Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Lucile Shepard DeReign

(b) Address Caruthersville, Mo.

17. (a) Removal (b) Date thereof 12/1/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Arrow Rock, Missouri

18. (a) Signature of funeral director Meyer-Pfizinger Fun.

(b) Address Kirkwood, Mo.

19. (a) 12-1-47 (b) Carl A. Harp
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96
(c) City or town Ballwin
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 30
year 1947 hour 3 minute 00 A.

21. I hereby certify that I attended the deceased from September 2nd 1946 to November 30th 1947
that I last saw him alive on November 29th 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to 93d

Other conditions Chronic Myocarditis
(Include pregnancy within 5 months of death)

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 place?

While at work? _____ (Specify type of place)
(e) Means of injury 11

23. Signature R. D. Janson M.D. (M. D. or other)
Address Manchester Mo. Date signed 11/30/47

MAR 1 1948

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.....

John M. Meyer

Licensed Embalmer No.....

3288

P. O. Address.....

Richmond 22

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.