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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4685

FILED MAR 14 1949

State File No.

41
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BIRTH NO. _____ REG. DIST. NO. 134 PRIMARY REG. DIST. NO. 5495 Registrar's No. 5

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|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Harrison</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Harrison</u> | |
| b. CITY OR TOWN <u>Rural - Trailcreek</u> | | c. CITY OR TOWN <u>Rural - Trailcreek</u> | |
| c. LENGTH OF STAY (In this place) <u>8 yrs</u> | | d. STREET ADDRESS (If rural, give location) <u>9 1/2 W. Mt. Mariah.</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>None - own home</u> | | | |

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| 3. NAME OF DECEASED a. (First) <u>Ocie</u> b. (Middle) <u>Olive</u> c. (Last) <u>Shepard</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 23 - 49</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u> | 8. DATE OF BIRTH <u>Oct. 31 - 1904</u> |
| 9. AGE (In years last birthday) <u>44</u> | IF UNDER 1 YEAR Months <u>3</u> Days <u>23</u> | IF UNDER 1 HR. Hours <u></u> Min. <u></u> | 11. BIRTHPLACE (State or foreign country) <u>Merced Co. Cal.</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>House work</u> | |
| 13a. FATHER'S NAME <u>Clarence Henry Turner</u> | | 13b. MOTHER'S MAIDEN NAME <u>Charlotte Dennison Nelson</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>Delmer Lee Shepard</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>no</u> | |
| 17. INFORMANT'S SIGNATURE OR NAME <u>Delmer Lee Shepard</u> | | ADDRESS <u>Ridgeway, Mo.</u> | |

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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH <u>12 hours.</u> |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Hemorrhage (Abdominal).</u> exact cause unknown. | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Possibly- ectopic pregnancy</u> or malignant condition that existed as unknown. DUE TO (c) <u>Recurrent, gall bladder attacks for several years.</u> | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) ¹ (COUNTY) (STATE) |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from 2-22 (3 PM) 1949, to 2-22 (4 PM) 1949, that I last saw the deceased alive on 2-22 (4 PM) 1949, and that death occurred at 1:30 A.M., from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) <u>Alfred C Taff D.O.</u> | 23b. ADDRESS <u>Cainsville Mo</u> | 23c. DATE SIGNED <u>3-2-49</u> |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>Feb 25 - 49</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Yoshen Cemetery</u> |
| 24d. LOCATION (City, town, or county) (State) <u>1 1/2 M. N. Yoshen Mo</u> | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert R. Woffers - Ridgeway Mo</u> | |
| DATE REC'D BY LOCAL REG. <u>3/4/1949</u> | REGISTRAR'S SIGNATURE <u>S. Pha Shaw</u> | |

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student

Herold W. Boggers
Student Embalmer

Signed

Robert R. Boggers

Licensed Embalmer No.

35-76

P. O. Address

Ridgeway m

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.