

FILED JUN 5 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16484**

BIRTH NO. 27120-50 REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 510

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) Springfield		c. CITY (If outside corporate limits, write RURAL and give township) Springfield ^{n39U}	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 1540 N. Weller Avenue	
d. FULL NAME OF HOSPITAL OR INSTITUTION St John's Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) Baby Jo	b. (Middle) MARIE	c. (Last) Shepherd	4. DATE OF DEATH (Month) (Day) (Year) 5 31 50
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) never married	8. DATE OF BIRTH 5-29-50	9. AGE (In years last birthday) 42	IF UNDER 1 YEAR 30	IF UNDER 24 HRS. 30
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Springfield, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Edward Carl Shepherd	13b. MOTHER'S MAIDEN NAME Norma Lee Ely	14. NAME OF HUSBAND OR WIFE none
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Mr. Shepherd	ADDRESS 1540 N. Weller
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Atelectasis, congenital, both lungs		From birth
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) (Baby of dead diabetic mother - Baby's death wt 12 lb 14 oz) DUE TO (c) 7691		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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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) (COUNTY) (STATE)
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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?
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22. I hereby certify that I attended the deceased from 5/29, 1950, to 5/31, 1950, that I last saw the deceased alive on 5/31, 1950, and that death occurred at 11 AM, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Shepherd, M.D.	23b. ADDRESS Springfield, Mo.	23c. DATE SIGNED 5/31/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 1 June 1950	24c. NAME OF CEMETERY OR CREMATORY Thayer Cemetery	24d. LOCATION (City, town, or county) (State) Thayer, Missouri
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DATE REC'D BY LOCAL REG. 6-1-50	REGISTRAR'S SIGNATURE W.E. Handley MD	25. FUNERAL DIRECTOR'S SIGNATURE Frank C. Thayer	ADDRESS Springfield, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

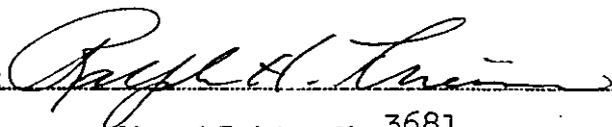
STATEMENT BY LICENSED EMBALMER

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
Student Embalmer

Signed  _____

Licensed Embalmer No. 3681

P. O. Address Springfield, Missouri

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.