

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41856**

FILED JAN 4 1951

BIRTH NO. _____ REG. DIST. NO. **298** PRIMARY REG. DIST. NO. **4448** Registrar's No. **27**

1. PLACE OF DEATH a. COUNTY RAY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Ray	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN LAWSON	c. LENGTH OF STAY (In this place) 13 months	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lawson 0890	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) 0	

3. NAME OF DECEASED (Type or Print) a. (First) CLYDE b. (Middle) ANDREW c. (Last) KEPHART			4. DATE OF DEATH (Month) (Day) (Year) DECEMBER-10-1950		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED; NEVER MARRIED, WIDOWED, DIVORCED (Specify) DIVORCED	8. DATE OF BIRTH APRIL 16-1927	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR: Months 7 Days 24
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER		10b. KIND OF BUSINESS OR INDUSTRY BARBERING		11. BIRTHPLACE (State or foreign country) ANTHONY, KANSAS	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME ANDREW NEWTON KEPHART	13b. MOTHER'S MAIDEN NAME Nancy ERWIN	14. NAME OF HUSBAND OR WIFE ETHEL KEPHART
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or date of service) WORLD WAR I	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME Mrs. Jean Bills ADDRESS Kansas City

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) Coronary Occlusion		1 hr.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Myocarditis		10 yrs.
	DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		H 5-21
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

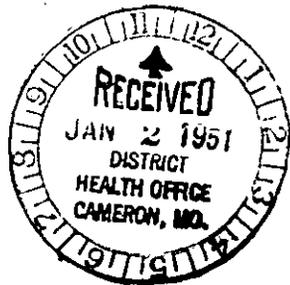
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY) TOWN, OR TOWNSHIP (COUNTY) (STATE) Lawson Ray Mo.
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Sept.**, 1950, to **Dec 10, 1950**, that I last saw the deceased alive on **Dec 9**, 1950, and that death occurred at **4 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. J. Buehner M.D.	23b. ADDRESS Lawson Mo	23c. DATE SIGNED Dec 12, 1950
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12-13-1950	24c. NAME OF CEMETERY OR CREMATORY Crown Hill cemetery	24d. LOCATION (City, town, or county) (State) Excelsior Springs Mo.
DATE REC'D BY LOCAL REG. Dec 12, 1950	REGISTRAR'S SIGNATURE Mr. Raymond	25. FUNERAL DIRECTOR'S SIGNATURE 364	ADDRESS Lawson Mo.

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

Lindell K. Jassman

Licensed Embalmer No. *4589*

Excelsior Springs, Mo.

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.