

FILED FEB 16 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6924**
Registrar's No. **313**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **3063**

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY St. Louis | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri | |
| b. CITY OR TOWN Clayton | | b. COUNTY St. Louis | |
| c. LENGTH OF STAY (in this place) | | c. CITY OR TOWN 9 1/2 Kinloch | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis County Hospital | | d. STREET ADDRESS (If rural, give location) 1140 Scott Ave. | |

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|--|--|---------------------------|-------------|---|--|------------------------------------|--|---|---|--------------------------------|--|--|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) Willie | | | b. (Middle) | | | c. (Last) Sheppard | | | 4. DATE OF DEATH (Month) (Day) (Year) 2 1 51 | | | | |
| 5. SEX M 2 | | 6. COLOR OR RACE N | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 1 | | 8. DATE OF BIRTH 11-24-1900 | | 9. AGE (In years last birthday) 50 | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | | | 11. BIRTHPLACE (State or foreign country) Helen Arkansas 1 | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |

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|---|--|--|--|--|--|--|--|--|--------------------------------|--|--|
| 13a. FATHER'S NAME Unknown | | | 13b. MOTHER'S MAIDEN NAME Unknown | | | 14. NAME OF HUSBAND OR WIFE Louise Sheppard | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | 16. SOCIAL SECURITY NO. 192-03-7744 | | | 17. INFORMANT'S SIGNATURE OR NAME Louise Sheppard | | | ADDRESS 1140 Scott Ave. | | |

| | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|----------------------------------|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) UREMIA | | | | | | | 10 d | |
| *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | | *ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) ARTERIOLAR NEPHROSCLEROSIS | | | | | | | 2 wks. | |
| | | DUE TO (c) GEN'L ARTERIOSCLEROSIS | | | | | | | 5 yrs | |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. CEREBRAL VASCULAR HEMMORRHAGE | | | | | | | 3 wks | |

| | | | | | | | | | |
|--|--|--|--|--|---|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION 446X | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | | 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 **12-31-1950**, to **2-1-1951**; that I last saw the deceased alive on **2-1-1951**, and that death occurred at **5:15 P.m.**, from the causes and on the date stated above.

| | | | | | | | | |
|--|--|-------------------------------|---|---|--|---|--|--|
| 23a. SIGNATURE Robert L. Jeffrey MD (Degree or title) | | | 23b. ADDRESS 6015 Brentwood Church 5, Mo | | | 23c. DATE SIGNED 2-3-51 | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE Feb. 3, 1951 | | 24c. NAME OF CEMETERY OR CREMATORY Washington Park | | 24d. LOCATION (City, town, or county) (State) St. Louis County Mo. | | |

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|--|--|--|--|---|--|-------------------------------------|--|
| DATE REC'D BY LOCAL REG. 2/3/51 | | REGISTRAR'S SIGNATURE Herbert R. Donhe MD | | 25. FUNERAL DIRECTOR'S SIGNATURE Boyd Bros. Funeral Home | | ADDRESS 1538 Six So. Kinloch | |
|--|--|--|--|---|--|-------------------------------------|--|

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

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed Edward A. Flynn

Licensed Embalmer No. 4744

P. O. Address 4548² Page

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.