

FILED SEP 28 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32456

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 541 Registrar's No. 2107

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri	
b. CITY (If outside corporate limits, write RURAL and give township) Clayton		b. COUNTY St. Louis	
c. LENGTH OF STAY (If this place) 1 day		c. CITY OR TOWN Overland 422	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis County Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
STREET ADDRESS (If rural, give location) 3200 Coles Ave. 14			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Piercy</u> b. (Middle) <u>Shepardson</u> c. (Last) <u>Shepardson</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>9 2 54</u>		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Oct. 21st, 1880	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broom Maker		10b. KIND OF BUSINESS OR INDUSTRY Broom Mfr.		11. BIRTHPLACE (City and State or Foreign Country) / Macoupin County, Illinois	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME William Shepardson	13b. MOTHER'S MAIDEN NAME Mary Boswell	14. NAME OF HUSBAND OR WIFE Late Rosa Shepardson
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME Clarence Wm. Shepardson	ADDRESS 3200 Coles Ave.
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Sub-Arachnoid Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-2 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Cardiovascular Dis.</u>		
	DUE TO (c) <u>Arterial + Arterioles Nephrosclerosis</u>		
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 4221	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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 9-1, 1954, to 9-2, 1954, that I last saw the deceased alive on 9-2, 1954, and that death occurred at 4:45 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Casper D. Ray, M.D.</u>	(Degree or title)	23b. ADDRESS <u>601 So. Brentwood</u>	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9-4-54	24c. NAME OF CEMETERY OR CREMATORY Friends Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri
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DATE REC'D BY LOCAL REG. 9/5/54	REGISTRAR'S SIGNATURE <u>Heber R. Romkey</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Malvin F. Feutz</u>	ADDRESS General Home 4828 Nat'l Bridge Blvd. (Licensed Embalmer - Statement on Reverse Side)
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WRITE PLAINLY—USING UNFADEING 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.....
Signature of Student Embalmer

Signed... *Ralph C. Junderson*.....

Licensed Embalmer No. *427*

P. O. Address... *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.