

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10742

State File No.

FILED APR 11 1955

BIRTH NO. _____ REG. DIST. NO. 381 PRIMARY REG. DIST. NO. 44-15 Registrar's No. 23

1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Sullivan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Milan</u>		c. CITY OR TOWN <u>Milan</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>79 yrs</u>		e. STREET ADDRESS (If rural, give location) <u>1050</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) <u>Luther</u> c. (Last) <u>Shepherd</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>4-1-55</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4-28-1875</u>	9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Days <u>11</u> Hours <u>31</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Reger - Mo</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13a. FATHER'S NAME <u>Wm. Shepard</u>		13b. MOTHER'S MAIDEN NAME <u>Camora & King</u>	
14. NAME OF HUSBAND OR WIFE <u>Camora Fields</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT'S SIGNATURE OR NAME <u>Camora Shepard</u>		ADDRESS <u>Milan Mo</u>			

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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____				
		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? 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) <u>331X</u>	

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>March 29, 1955</u> to <u>April 1, 1955</u> , that I last saw the deceased alive on <u>March 31, 1955</u> , and that death occurred at <u>3:30 a.m.</u> , from the causes and on the date stated above.					

23a. SIGNATURE <u>J. R. McArthur</u> (Degree or title)		23b. ADDRESS <u>M. D. O. Brewery, Mo.</u>		23c. DATE SIGNED <u>4-5-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>4-3-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cem</u>	
24d. LOCATION (City, town, or county) (State) <u>Milan Mo</u>		DATE REC'D BY LOCAL REG. <u>4-6-1955</u>		REGISTRAR'S SIGNATURE <u>Mrs. H. B. Harris</u> <u>320-</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Shelley E. Schaefer</u>		ADDRESS <u>Milan Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed..... *Dwight Schoene*

Licensed Embalmer No. *2667*

P. O. Address *Mt. Airy - N.C.*

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.