

Health, Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
J. S. Wells M.D.

FILED OCT 3 1956

STANDARD CERTIFICATE OF DEATH

30946

STATE FILE NUMBER 4102

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4102

1. PLACE OF DEATH a. COUNTY JACKSON			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN KANSASCITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2010 Park Ave		Length of stay in 1b 50 yrs	d. STREET ADDRESS 2010 Park Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) LAWSON _____ SHEPHERD			4. DATE OF DEATH SEPT 13th 1956		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 28th 1881	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired laborer		10b. KIND OF BUSINESS OR INDUSTRY construction	11. BIRTHPLACE (City and state or country) Hustonia Missouri		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME HENRY SHEPHERD			14. MOTHER'S MAIDEN NAME LOTTIE BOSWELL		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 487-034-669A	17. INFORMANT Address ELLA MAE SHEPHERD 2010 Park Ave. (wife)		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive heart disease</i> DUE TO (b) <i>Generalized arteriosclerosis?</i> DUE TO (c) <i>Chronic Interstitial Nephritis</i>					INTERVAL BETWEEN ONSET AND DEATH <i>3-6 yrs</i> <i>3-4 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <i>443X</i>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>none</i>		
20c. TIME OF INJURY Hour, Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
21. I attended the deceased from <i>Sept 8-56</i> to <i>Sept 13th 1956</i> and last saw him alive on <i>9-13-56</i> . Death occurred <i>at</i> _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>J. S. Wells M.D.</i>		(Deleged or Title)	22b. ADDRESS <i>2122 - E - 15th K.C.</i>		22c. DATE SIGNED <i>9-18-56</i>
23a. BURIAL, CREATION, REMOVAL (Specify) BURIAL	23b. DATE <i>Sept 18th 56</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Lincoln Cemetery</i>		23d. LOCATION (City, town, or county) <i>KansCity, Mo.</i> (State)	
24. FUNERAL DIRECTOR ADDRESS <i>ADKINS FUNERAL HOME Kansas City, Mo.</i>		25. DATE RECD. BY LOCAL REG. <i>9-18-56</i>	26. REGISTRAR'S SIGNATURE <i>neva minshall</i>		

(Licensed Embalmer's Statement on Reverse Side)

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.....
W. H. B. B. B.

Licensed Embalmer No.....
412

P. O. Address.....
K. C. N.

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.