

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16308
STATE FILE NUMBER

FILED JUN 3 1957

Registration District No. 42 Primary Registration District No. 5123 Registrar's No. 571

Health,
Welfare
Public
Service

300
1-56

All symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN RURAL, AGENCY TOWNSHIP Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN St. Joseph <i>0117</i> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Rt #4, St. Joseph Length of stay in lb 60 yrs		d. STREET ADDRESS (If outside, give location) Rural Rt #4 Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>First Middle Last</i> Sylvester Hammy Shepherd			4. DATE OF DEATH Month May Day 20 Year 1957
5. SEX male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 17, 1889
9. AGE (In years last birthday) 67		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) Buchanan Co, Mo
13. FATHER'S NAME James Shepherd		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. MOTHER'S MAIDEN NAME Mary Hammy		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Address Leona Shepherd St. Joseph, Mo	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Coronary Occlusion			INTERVAL BETWEEN ONSET AND DEATH 5 or 6 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) 4201			
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.)
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 1935 to 12-13-56 and last saw him her alive on 12-13-56 Death occurred at 2:00 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) W E Hartscock M.D.		22b. ADDRESS St. Joseph, Mo. 3132 St. Joseph Ave.	22c. DATE SIGNED 5/22/57
23a. BURIAL, CREMATION, REINTERMENT (Specify) Burial	23b. DATE 5/22/57	23c. NAME OF CEMETERY OR CREMATORY King Hill Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph, Mo
24. FUNERAL DIRECTOR ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. May 27, 1957	26. REGISTRAR'S SIGNATURE Edwin M. Allison

(Licensed Embalmer's Statement on Reverse Side)

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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, ~~by~~ Student Embalmer No. working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed *Joseph*.....
Licensed Embalmer No. 398

P. O. Address *Joseph*.....

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.