

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009655
STATE FILE NUMBER
1517

FILED APR 8 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1517

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-57

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 KCMO		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Gen. Hospital # 1		Length of stay in 1b 45 years	d. STREET ADDRESS (If outside, give location) 1402 Jefferson St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First LOIS Middle Rhoda Last Shepherd			4. DATE OF DEATH Month Mar Day 20 Year 1959			
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 26, 1900	9. AGE (In years last birthday) 58	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker-AT HOME	10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (City and state or country) Fort Scott, Kansas	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME George Randolph	13b. MOTHER'S MAIDEN NAME Rhoda Delzell	14. NAME OF HUSBAND OR WIFE Ashton Shepherd
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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	16. SOCIAL SECURITY NO. 515-24-1313	17. INFORMANT Lena Wilson, 1402 Jefferson, K.C. Mo.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Glomerulonephritis		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	592-*
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour _____ 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 _____
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21. I attended the deceased from 3-19-59 to 3-20-59 and last saw her alive on 3-20-59 Death occurred at 8:20 P. m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <i>Abraham Gelperin</i> (Degree or title)	22b. ADDRESS K.C., Mo.	22c. DATE SIGNED 3-21-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Mch. 24, 1959	23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery	23d. LOCATION (City, town, or county) (State) Fort Scott Kansas
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24. FUNERAL DIRECTOR D.W. Newcomer's Sons, K.C. Missouri	25. DATE RECD. BY LOCAL REG. 3-23-59	26. REGISTRAR'S SIGNATURE <i>Reva Marshall</i>
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Abraham Gelperin M.D. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.

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

Licensed Embalmer No.....

P. O. Address.....

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.