

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017940

STATE FILE NUMBER 2461

FILED JUN 9 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2461

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		c. CITY OR TOWN Independence	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA Hospital		d. STREET ADDRESS (If outside, give location) 7005 12200 E. 53rd St.	
3. NAME OF DECEASED (Type or print) First GEORGE Middle PHILLIP Last SHEPARD		4. DATE OF DEATH Month 5th Day 14th Year 1959	
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 6-20-1919
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Repairman		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Oklahoma City, Oklahoma
13a. FATHER'S NAME Hartley Shephard		13b. MOTHER'S MAIDEN NAME Gertrude Houck	14. NAME OF HUSBAND OR WIFE Jessie Shephard
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 484 14 0616	17. INFORMANT Address VA HOSPITAL RECORDS K. C. 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) Inanition advanced; pulmonary edema Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) _____ DUE TO (c) Extensive mucoid carcinoma of rectum PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 154X
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 _____ a.m. _____ p.m.		20d. INJURY OCCURRED WHILE AT <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. Attended the deceased from 4-29-59 to 5-14-59 Death occurred at 6:15 p. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) A. J. WILLIAMS, M.D.		22b. ADDRESS VA Hospital, Kansas City, Mo.	22c. DATE SIGNED 5-15-59
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE MAY 18, 1959	23c. NAME OF CEMETERY OR CREMATORY GREEN LAWN CEM	23d. LOCATION (City, town, or county) (State) KANSAS CITY, MO.
24. FUNERAL DIRECTOR ADDRESS D W Newcomer's Son, Mo		25. DATE RECD. BY LOCAL REG. 5-18-59	26. REGISTRAR'S SIGNATURE Wesley Minshall

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. 3035

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.