

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027744

FILED VS AUG 10 1959

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2112 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Manchester		Length of stay in 1b 7 Mos.	c. CITY OR TOWN Maplewood Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Manchester N. Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2618 Laclede Station Rd. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First GRACE Middle DARLING Last SHEPARD			4. DATE OF DEATH Month August Day 4 Year 1959		
---	--	--	---	--	--

5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-19-1881	9. AGE (last birthday) 78	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
-------------------------	----------------------------------	---	--------------------------------------	-------------------------------------	--------------------------------	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	10b. KIND OF BUSINESS OR INDUSTRY Housekeeper	11. BIRTHPLACE (City and state or country) Cincinnati, Ohio	12. CITIZEN OF WHAT COUNTRY USA
--	---	---	---

13a. FATHER'S NAME Unknown Jethia	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Thomas Shepard
---	---	--

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. 492-36-2753	17. INFORMANT Address Mrs. Fred H. Wolf, above
---	---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-VASCULAR DISEASE		INTERVAL BETWEEN ONSET AND DEATH 3
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) -	
	DUE TO (c) -	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) NONE		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
--	--	---	--

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.)
---	---	--

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 **MAY 12, 1959** to **AUG. 4, 1959** and last saw her ^{her} _{him} alive on **AUG. 4, 1959**
Death occurred at **11:15 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) B.R. Loving M.D.	22b. ADDRESS Ballwin, Mo.	22c. DATE SIGNED 8-6-59
---	-------------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-6-1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
--	------------------------------	---	--

24. FUNERAL DIRECTOR ADDRESS JAY B. SMITH, Maplewood, Mo.	25. DATE RECD. BY LOCAL REG. 8-6-59	REGISTRAR'S SIGNATURE John C. Murphy M.D.
---	---	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed H. Burgess

Licensed Embalmer No. 4029

P. O. Address Maplewood

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.