RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS SEP 28 1959

59-032157

STATE FILE NUMBER

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 127

1. PLACE OF DEATH
a. COUNTY: Howell
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: West Plains — Length of stay in 1b: 10 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: West Plains Memorial Hosp — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Texas b. COUNTY:
c. CITY OR TOWN: Borger — Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Eunice Middle: E. Last: Sheppard
4. DATE OF DEATH: Month: Sept. Day: 19 Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 1/18/1886
9. AGE (last birthday): 73 — 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: Housewife
11. BIRTHPLACE (City and state or country): Eddy, Texas
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: unknown
13b. MOTHER'S MAIDEN NAME: unknown
14. NAME OF HUSBAND OR WIFE: Samuel Sheppard
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Samuel Sheppard Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 10 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
~~DUE TO (b)~~ Hypertension + Arteriosclerosis
~~DUE TO (c)~~ Cardiac Asthma
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 10 Sept 59, to 19-9-59 and last saw her alive on 19-9-59
Death occurred at 6:20 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: [signature] (Degree or title) M.D.
22b. ADDRESS: West Plains, Mo.
22c. DATE SIGNED: 22-9-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 9/21/59
23c. NAME OF CEMETERY OR CREMATORY: Thayer
23d. LOCATION (City, town, or county) (State): Thayer, Missouri

24. FUNERAL DIRECTOR: [signature] ADDRESS: Thayer Mo
25. DATE RECD. BY LOCAL REG.: 9-22-59
26. REGISTRAR'S SIGNATURE: Beatrice Cook

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

SEP 8 9 1959

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 Leland Carter

Licensed Embalmer No. 4516

P. O. Address West Plain

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