

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
 FILED VS DEC 29 1960

-60-045481

STATE FILE NUMBER

Registration District No. 72 Primary Registration District No. 4134 Registrar's No. 179

1. PLACE OF DEATH a. COUNTY <b>Clay</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Platte</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Smithville</b>		Length of stay in 1b <b>Life</b>		c. CITY OR TOWN <b>Smithville</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Smithville Community Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3 Miles So. West Smithville</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Patrick</b> Middle <b>Nash</b> Last <b>Shepherd</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>28</b> Year <b>1960</b>				
5. SEX <b>Ma</b>	6. COLOR OR RACE <b>Wh</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>1-22-73</b>	9. AGE (last birthday) <b>87</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (City and state or country) <b>Clay Co., Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>William M. Shepherd</b>			13b. MOTHER'S MAIDEN NAME <b>Sallie Johnson</b>			14. NAME OF HUSBAND OR WIFE <b>Katherine Shepherd</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>489-44-4008</b>		17. INFORMANT Address <b>Jack Shepherd Smithville, Mo.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Bronchopneumonia</b>							INTERVAL BETWEEN ONSET AND DEATH <b>21 days</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Multiple cerebral thromboses</b>							<b>3 mo</b>	
DUE TO (c) <b>Generalized Arteriosclerosis</b>							<b>10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Old myocardial infarction</b>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Month, Day, Year								
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 <b>Nov 7, 1960</b> to <b>Nov. 28, 1960</b> and last saw him alive on <b>Nov. 28, 1960</b> Death occurred at <b>3:30</b> <b>P</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <i>W. B. Lewis MD</i>				22b. ADDRESS <b>Smithville, Missouri</b>			22c. DATE SIGNED <b>11-30-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11-30-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>I.O.O.F. Cemetery</b>			23d. LOCATION (City, town, or county) (State) <b>Smithville, Missouri</b>		
24. FUNERAL DIRECTOR <b>McComas Funeral Home</b>		ADDRESS <b>Smithville, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>11-30-60</b>		26. REGISTRAR'S SIGNATURE <i>Marguerite Hudgens</i>		

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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Donald W. Hanks

Licensed Embalmer No. 4520

P. O. Address Smithville, Va

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