

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-008588

AMENDED

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 42

STATE FILE NUMBER

FILED MAR 27 1961

1. PLACE OF DEATH a. COUNTY <b>Howell</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Howell</b>			
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>West Plains</b>			Length of stay in 1b <b>6 days</b>		c. CITY OR TOWN <b>West Plains</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>West Plains Mem Hosp</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>205 Summit</b>	
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Jeremiah</b> Last <b>Shepard</b>		4. DATE OF DEATH Month <b>March</b> Day <b>15</b> Year <b>1961</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</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>2-22-75</b>		9. AGE (last birthday) <b>86</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Jaques Mfg. Co.</b>		11. BIRTHPLACE (City and state or country) <b>Muncie, Indiana</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Jeremiah Shepard</b>			13b. MOTHER'S MAIDEN NAME <b>Mary Ann Patterson</b>			14. NAME OF HUSBAND OR WIFE <b>Vina Shepard</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>205 Summit Vina Shepard, West Plains, 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>Senile dementia</b> DUE TO (b) <b>Fracture hip</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>4 day</b> <b>6 day</b>
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input checked="" 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.) <b>fell at home</b>			
20c. TIME OF INJURY Hour <b>3</b> Month <b>9</b> Day <b>61</b> a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>West Plains Howell 1 Mo.</b>	
21. I attended the deceased from <b>3 9 61</b> to <b>3 15 61</b> and last saw her/him alive on <b>3 15 61</b> Death occurred at <b>2 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>J B Stoll M D</b>				22b. ADDRESS <b>West Plains MO</b>		22c. DATE SIGNED <b>3/17/61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3-18-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>West Plains, Missouri</b>	
24. FUNERAL DIRECTOR <b>CARTER Funeral Home West Plains mo</b>				25. DATE RECD. BY LOCAL REG. <b>3-21-61</b>		26. REGISTRAR'S SIGNATURE <b>Beatrice Cook</b>	

DATE AMENDED

INSTEAD OF THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

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

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

Signed *Richard Carter*

Licensed Embalmer No. 4516

P. O. Address West Plains

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.