

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-012124

AMENDED

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 575 STATE FILE NUMBER

1. PLACE OF DEATH
 a. COUNTY ST. Louis
 b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN CLAYTON Length of stay in 1b 12 days
 c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. Louis Co. Hosp Inside Limits Yes No
 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE Mo. b. COUNTY ST. Louis
 c. CITY OR TOWN Kinloch Inside Limits Yes No
 d. STREET ADDRESS (if outside, give location) 5565 Mable St. Reside on Farm Yes No

3. NAME OF DECEASED First Middle Last 4. DATE OF DEATH Month Day Year
OTIS SHEPHERD FEB. 25. 1961

5. SEX Male 6. COLOR OR RACE Negro 7. Married Never Married Widowed Divorced
 8. DATE OF BIRTH July 14, 1921 9. AGE (last birthday) 39 IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cooks - Helper 10b. KIND OF BUSINESS OR INDUSTRY Civil Sec. Scott Field 11. BIRTHPLACE (City and state or country) ORiley, Miss. 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME James L. Sheppard 13b. MOTHER'S MAIDEN NAME Allie Harris 14. NAME OF HUSBAND OR WIFE Louise Sheppard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW2 17. INFORMANT Address Louise Sheppard 5565 Mable St.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Adhesive pericarditis
 DUE TO (b) Pericardial metastases
 DUE TO (c) Carcinoma of the Lung
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Obstructive pneumonitis + abscess 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 12-14-60 to 2-25-61 and last saw her/him alive on 2-25-61
 Death occurred at 5:45 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) Albert L. Howe M.D. 22b. ADDRESS 601 S. Brentwood, Clayton, Mo. 22c. DATE SIGNED 2/26/61

23a. BURIAL, CREMATION, REMOVAL (Specify) Bucial 23b. DATE 3/3/61 23c. NAME OF REMOVAL OR CREMATORY NATIONAL Jefferson 1249 S. Chas. St. St. Louis Co. 23d. LOCATION (City, town, or county) State

24. FUNERAL DIRECTOR ADDRESS Bayl Bros 562 S. Chas. Rd. Kinloch (90) 25. DATE RECD. BY LOCAL REG. 2-28-61 26. REGISTRAR'S SIGNATURE John B. Murphy M.D.

DATE AMENDED
 INSTEAD OF
 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 Henry C. Williams

Licensed Embalmer No. 4781

P. O. Address 1305 Walton St.
St. Louis

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.