MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7759 STATE FILE NUMBER 61-031101

FILED AUG 31 1961

1. PLACE OF DEATH
a. COUNTY ST LOUIS MO
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN — Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A Homer Phillip — Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO b. COUNTY
c. CITY OR TOWN ST LOUIS MO — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 3025 Dickson ST — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First OTHA Middle PAUL Last SHEPARD
4. DATE OF DEATH Month 8 Day 17.61 Year
5. SEX male
6. COLOR OR RACE negro
7. Married ☐ Never Married ☑ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 5/17/45
9. AGE (last birthday) 16.yrs — 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)
10b. KIND OF BUSINESS OR INDUSTRY school Student
11. BIRTHPLACE (City and state or country) ST LOUIS.MO
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME HAZEL .F.SHEPARD
13b. MOTHER'S MAIDEN NAME KATIE Mae.DeFRANCE
14. NAME OF HUSBAND OR WIFE not married
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 KATIE Mae. SHEPARD Address 3025 DicksonS ST

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Respiratory Paralysis; Contrib: Electrocution suffered when dec'd touched shorted
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Lamp in home at 4220 Washington
DUE TO (c) about 10 P M on 8-17-61 Accident
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 914.0-22
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.) 21 Home
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at 10:40 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [signature] Deputy Coro
22b. ADDRESS 1300 Clark
22c. DATE SIGNED 8-21-61

23a. BURIAL, CREMATION, REMOVAL (Specify) moter
23b. DATE 8/23/61/
23c. NAME OF CEMETERY OR CREMATORY GREENWOOD Cemetery
23d. LOCATION (City, town, or county) (State) 6571 ST LOUIS AVE . MO

24. FUNERAL DIRECTOR ADDRESS PORTER Funeral HOME.3028 Dickson ST
25. DATE RECD. BY LOCAL REG. AUG 21 1961
26. REGISTRAR'S SIGNATURE [signature]

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
ITEM NO. SHOULD READ INSTEAD OF DATE AMENDED
BY AFFIDAVIT OF DOCUMENT

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 W. Calvin de Gordon

Licensed Embalmer No. 3489

P. O. Address 1123 N. Fay

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.