

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

25346  
-61-037341  
STATE FILE NUMBER

AMENDED

Registration District No. 4237 Primary Registration District No. 534 Registrar's No. 534

Registration No. FILED NOV 18 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Wyandotte</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Raytown</b>		c. CITY OR TOWN <b>Kansas City</b>	
Length of stay in 1b <b>1 mo.</b>		Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>8615 E. 81st. Ter</b>		d. STREET ADDRESS (If outside, give location) <b>416 N. 31st</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <b>MARTHA FRANKLIN SHEPPERD</b>			4. DATE OF DEATH <b>Oct. 28, 1961</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6/9/1866</b>
9. AGE (last birthday) <b>95 yrs.</b>		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) <b>homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	11. BIRTHPLACE (City and state or country) <b>Carroll Co. Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>William F. Standley</b>	
13b. MOTHER'S MAIDEN NAME <b>Martha Ann Head</b>		14. NAME OF HUSBAND OR WIFE <b>Leander L. Shepperd</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>none</b>	
17. INFORMANT <b>Lena M. Allison</b>		Address <b>8615 E. 81st ter.</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>Coronary occlusion</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>Arteriosclerotic coronary heart disease 10 yrs<sup>21</sup></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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 a.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>6 Oct 61</b> to <b>28 Oct 61</b> and last saw her <sup>her</sup> alive on <b>6 Oct 61</b> Death occurred at <b>28 Oct 61</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Jash M Daws MD</b>		22b. ADDRESS <b>Raytown Mo</b>	
22c. DATE SIGNED <b>30 Oct 61</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10 30 61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Maple Hill Cemetery</b>	
23d. LOCATION (City, town, or county) (State) <b>Kansas City, Ks.</b>			
24. FUNERAL DIRECTOR <b>Geo. F. Porter &amp; Sons</b>		ADDRESS <b>K.C.Ks.</b>	
25. DATE RECD. BY LOCAL REG. <b>10-31-61</b>		26. REGISTRAR'S SIGNATURE <b>Alba L. Craig</b>	

**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

*Howard J. Porter*

Licensed Embalmer No. 3751

P. O. Address 19th & Minnesota  
Kansas City, Ks

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.