

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

30844

**1. PLACE OF DEATH**

County Jackson Registration District No. 399 File No. \_\_\_\_\_  
 Township Kaw Primary Registration District No. \_\_\_\_\_ Registered No. 3868  
 City Kansas City Community Hospital St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Infant S. Shepherd  
 (a) Residence. No. 714 E. 8th St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Males 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 12 1929  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. \_\_\_\_\_  
 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Child  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Kansas City, Mo.  
 (STATE OR COUNTRY)

PARENTS  
 10. NAME OF FATHER Marion A. Shepherd  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) Missouri  
 12. MAIDEN NAME OF MOTHER Georgia B. Cady  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) Kansas

14. INFORMANT Mrs. Irving T. Cady  
 (Address) 714 E. 8th St. Kansas City

15. FILED 9/13 1929 M. M. Brown REGISTRAR  
Asst

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 12 - 1929  
 17. I HEREBY CERTIFY, That I attended deceased from 9/12/29  
 \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_  
 that I last saw him alive on 9/12 10:50 a.m., 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Prematurity  
160 B  
159  
 (duration) \_\_\_\_\_ mos. \_\_\_\_\_ da.  
 CONTRIBUTORY Placenta Praevia  
 (SECONDARY) (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
 IF NOT PLACE OF DEATH \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS \_\_\_\_\_  
 (Signed) H. C. Rippe M. D.  
9/13, 1929 (Address) 410 Carnegie Bldg  
 \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Blue Springs 770 DATE OF BURIAL 9-13 1929  
 20. UNDERTAKER J. W. Stanley Blue Springs 770 ADDRESS \_\_\_\_\_

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