

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

Do not use this space.  
**18405**

1. PLACE OF DEATH  
 County Jasper Registration District No. 411  
 Township Jasper Primary Registration District No. 2002  
 City Jasper (No.       ) St.        (Ward       )  
 2. FULL NAME Isabella Shepard  
 (a) Residence No. 308 corner St.        Ward         
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred 60 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 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 single  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 29 1845  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.  
85      2      29              
 8. OCCUPATION OF DECEASED Retired  
 (a) Trade, profession, or particular kind of work  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Viggo (STATE OR COUNTRY)         
 10. NAME OF FATHER J. A. Shepard  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Perms (STATE OR COUNTRY)         
 12. MAIDEN NAME OF MOTHER Darah Brown  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) New Jersey (STATE OR COUNTRY)       

14. INFORMANT Edna Seibert (Address) 308 corner Ave  
 15. FILED 5-15 1931 U. Brisson Clark REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-16 1931  
 17. I HEREBY CERTIFY, That I attended deceased from May 11 1931 to May 16 1931 that I last saw her alive on May 16 1931, and that death occurred, on the date stated above, at        m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Cerebral hemorrhage  
47. P  
99 (duration) 6 yrs. mos. da.

CONTRIBUTORY Arteriosclerosis (SECONDARY) (duration) 15 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED        IF NOT AT PLACE OF DEATH.         
 DID AN OPERATION PRECEDE DEATH? no DATE OF         
 WAS THERE AN AUTOPSY? no  
 WHAT TEST CONFIRMED DIAGNOSIS (Signed) S. B. Kibben M. D. , 19 (Address) 26 Goplin Hotel Bldg

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURES OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL mt Hope DATE OF BURIAL 5-18 1931

20. UNDERTAKER Harvey's ADDRESS Boxing St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. 86-2-2 JUN 26 1931



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH.**

County Gascon Registration District No. 411

Township Gascon Primary Registration District No. 2001

City Gascon (No. ....) St. .... Ward)

File No. ....

Registered No. ....

**2. FULL NAME** Isabella Shepard

(a) Residence. No. .... St. .... Ward. .... (If nonresident give city or town and State)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 21-1845

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min. 86 2 25

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....

(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....

(STATE OR COUNTRY)

14.

INFORMANT

(Address)

15.

FILED 7/3 31 1931

M. Wilson Clark  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/16 19 31

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19....., that I last saw him ..... alive on ..... 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

..... (duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH!.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.

, 19 (Address)

\*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

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-18405