LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

NOV 28 1934

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

1. PLACE OF DEATH

County Henry — Registration District No. 349 — File No. 39215

Township — Primary Registration District No. 4287 — Registered No. 22

City Calhoun (No. ..... St. ..... Ward)

2. FULL NAME George Albert Shepherd

(a) Residence. No. Calhoun Mo St. ..... Ward. ..... (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): widowed ~~Married~~

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July-4-1842

7. AGE: YEARS 92 — MONTHS 4 — DAYS 34 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Relied Mail Carried
(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): Spring field Ohio

PARENTS
10. NAME OF FATHER: William Shepherd
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): west virgina
12. MAIDEN NAME OF MOTHER: Nancy Bates
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): New york

14. INFORMANT: Mrs. Shepherd
(Address) Calhoun Missouri

15. FILED 11/9, 1934 Mrs. A. A. Gray REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 8, 1934

17. I HEREBY CERTIFY, That I attended deceased from Nov 3, 1934 to Nov 7, 1934 that I last saw him alive on Nov 6, 1934 and that death occurred, on the date stated above, at 3:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Embolism of popliteal artery right leg
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 99a
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED 99a
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) H. Newall, M. D.
, 19 (Address) Windsor Mo.

*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: Calhoun Cemetry — DATE OF BURIAL: 11-10 1934

20. UNDERTAKER: Fred Wilkinson — ADDRESS: Clinton Mo.

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.

WRITE PLAINLY, WITH UNFADING INKEPTING IS A PERMANENT RECORD

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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No.....

City..... (No....., ... St. .....Ward)

2. FULL NAME.....

(a) Residence. No..... 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

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.....

(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)

PARENTS

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....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17.
I HEREBY CERTIFY, That I attended deceased from.....
....., 19....., to....., 19.....
that I last saw h..... 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

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