

1939 OCT 12

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

32413
Do not use this space.

1. PLACE OF DEATH *2*

(a) County *Greene* Registration District No. *318*

(b) Township *1* Primary Registration District No. *2001* Registered No. *708*

(c) City *Springfield Mo* (a) Street No. _____ St.

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

2. PRINT FULL NAME *Mrs. Dhoelbe, Shepard*

(a) Residence, No. *2049 W. Phelps* St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *James W. Shepard*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *July 4 1895*

7. AGE YEARS *44* MONTHS *2* DAYS *14* If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

FATHER 13. NAME *Sol Roberts* 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

MOTHER 15. MAIDEN NAME *Rosa Walden* 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

17. INFORMANT (ADDRESS) *J. W. Shepard, 2049 W. Phelps*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Brookline* DATE *Sept 20*, 19*39*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Queen Funeral Home, 629 W. Walnut*

20. FILE NO. *Sept 20, 1939* Local Registrar *295*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept 14*, 19*39*

22. I HEREBY CERTIFY That I attended deceased from *one visit*, 19*39*, *9/17/39*

I last saw her alive on *9-17*, 19*39* Death is said to have occurred on the date stated above, at *11:20 a.m.*

The principal cause of death and related causes of importance were as follows:
Valvular Heart Disease

Date of onset _____

Other contributory causes of importance: *97.0*

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? *no*

If so, specify *Henry J. Keast*, M. D. (Signed) _____ (Address) *456 1/2 E. Com*

WHITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

I X 140228

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

Registered Apprentice No....., working under my personal supervision.

Signed..... *Floyd W. Ford*

Licensed Embalmer No. *2910*

P. O. Address *629 W Walnut*

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 this body is not embalmed, above space should be left blank.

A