S. No. 2
OM—2-43

FILED MAY 5 1943

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 13412

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1835

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2925 Flora Avenue (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ---------- (Specify whether In this community 59 Years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City (If outside city or town limits, write "RURAL") 3 8

(d) Street No. 2925 Flora Avenue (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country ------- 0

3. (a) PRINT FULL NAME Mr. Chester Croy Shepherd

3. (b) If veteran, name war None

3. (c) Social Security No. 490-16-7864

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs. Lydia Shepherd

6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased March (Month) 23 (Day) 1868 (Year)

8. AGE: Years 75 Months 0 Days ~~23~~ 22 If less than one day hr. min.

9. Birthplace Robinson (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Superintendent (retired)

11. Industry or business Loose-Wiles Biscuit Co.

FATHER
12. Name Mathias Shepherd
13. Birthplace (City, town, or county) Ohio (State or foreign country)

MOTHER
14. Maiden name Angeline Mc Grew
15. Birthplace (City, town, or county) Indiana (State or foreign country)

16. (a) Informant Mrs. Lydia Shepherd

(b) Address 2925 Flora Avenue

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April 17, 1943 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah Cemetery

18. (a) Signature of funeral director D. H. Newcomer's Sons

(b) Address 1401 Brush Creek Blvd.

19. (a) 4-17-43 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 15th year 1943 hour 10 minute 45 P.M.

21. I hereby certify that I attended the deceased from April 5, 1943, to April 15, 1943 that I last saw him alive on April 15, 1943; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Broncho-pneumonia	6 days
Due to 93D	
Due to	
Other conditions (Include pregnancy within 3 months of death): Chronic Myocarditis	Unknown

Major findings: Of operations None

Of autopsy None

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) No

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature Kenneth G. Davis (M. D. or other) M.D.

Address 201 Plaza Theater Bldg. Kansas City Mo Date signed 4-16-43

(Licensed Embalmer's Statement on Reverse Side)

201 Rayonkeable Bldg
231 W. 47th St Eastlawn

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 H C Newcomer Jr

Licensed Embalmer No. 4043

P. O. Address K C Mo

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, fact should be so stated above.