

ILLU JAN 5 1944

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5425

1. PLACE OF DEATH:

(a) County JACKSON  
(b) City or town RANSAS CITY  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: MARTY CLINIC HOSPITAL OLSMCEE  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 173 DAYS  
(Specify whether  
In this community 1 WK.  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State NEBRASKA (b) County Dawson  
(c) City or town LEXINGTON  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country 2

3. (a) PRINT FULL NAME MRS. RACHELE SHEPHARD

3. (b) If veteran, name war NO 3. (c) Social Security No. NO.

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married. 2 divorced. WIDOWED

6. (b) Name of husband or wife William A. Sheppard 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased August 22 1888  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	55	3	27	hr. _____ min.

9. Birthplace Wlams Texas  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business \_\_\_\_\_

12. Name Samuel C. Malone

13. Birthplace Unknown Ind.  
(City, town, or county) (State or foreign country)

14. Maiden name Same Wlams

15. Birthplace Unknown Tex  
(City, town, or county) (State or foreign country)

16. (a) Informant Wm. B. Miller Garner

(b) Address 507 W. 18th

17. (a) Removed (b) Date thereof 12-20-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lexington Mem.

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

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 12-20-43 (b) D. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC. day 19<sup>TH</sup>  
year 1943 hour 11 minute P. M.

21. I hereby certify that I attended the deceased from Dec 18<sup>th</sup>  
1943 to Dec 19<sup>th</sup> 1943  
that I last saw her alive on Dec 19<sup>th</sup> 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia

Due to Influenza, 336

Due to Epidemic

Other conditions Stomach ulcer?  
(Include pregnancy within 3 months of death)

Major findings: Of operations none  
Of autopsy none

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(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? \_\_\_\_\_

While at work? ✓ (Specify type of place) (e) Means of injury ✓

23. Signature L.A. Marty (M. D. or other)  
Address 815 Mc Gee Date signed 12/20/43

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

MOTHER FATHER

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

815 M. Ave

**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**