

No. 2  
12-45  
17-39  
X47076

FILED MAR 24 1947  
318

State File No. \_\_\_\_\_

Registrar's No. 2249

Registration District No. \_\_\_\_\_

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St Louis

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

(c) Name of hospital or institution: City Hosp.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 0-5-0

(c) City or town St Louis Mo  
(If outside city or town limits, write "RURAL")

(d) Street No. 6801 Virginia Ave - 9  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME David Shepherd

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Mary Shepherd

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

7. Birth date of deceased Sept 3 1860  
(Month) (Day) (Year)

8. AGE: Years 86 Months 6 Day 8

If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation None

11. Industry or business None

12. Name 490 Shepherd

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

14. Maiden name Unknown

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

16. (a) Informant Priscilla Mues

(b) Address 7714 Mumfords Ave

17. (a) Burial (b) Date thereof 3/6/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Frank Gawn

18. (a) Signature of funeral director Frank Gawn

(b) Address 7420 Michigan Ave

19. (a) MAR 5 1947 (b) J. J. Budnick  
(Date received by Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 4  
year 1947 hour 2 minute 30 A.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_  
\_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above

Immediate cause of death: Fractured left hip  
intermedial dislocation  
when deceased fell to the  
floor at his home 6801  
Virginia Ave on Sept 21  
1947

Other conditions: None  
(Include pregnancy within 3 months of death)

Major findings: None  
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) Accident

(b) Date of occurrence Feb 21 1947

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

(d) Did injury occur in or about home, or in an industrial place, in public place? None

While at work? \_\_\_\_\_ (Specify type of place) (b) Means of injury to floor

23. Signature [Signature] (M. D. or other) 3

Address [Signature] Date signed 3/5/47

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

**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

*Olin E. Penell*

Licensed Embalmer No.:

*4148*

P. O. Address:

*Jeremy Mc*

**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.**

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (years, months or days)

3. (a) PRINT FULL NAME

David Shepherd

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex M

5. Color of race W

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased Sept 3  
(Month) (Day) (Year)

8. AGE: Years 86 Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day, hr. min.)

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Mo

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

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

(c) Place: burial or cremation \_\_\_\_\_

13. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 3-5-1947 (b) J. F. Bredeck  
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Year 1947 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

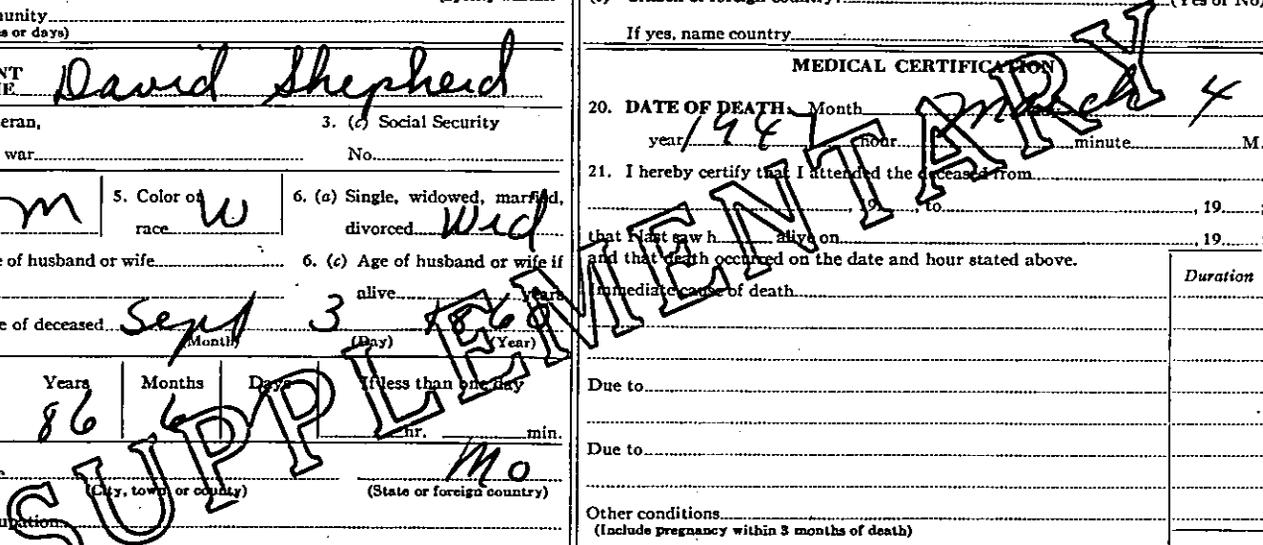
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_



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

APR 7 1947

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