

No. 300
1-10-47
5-17-39
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15321

FILED JUN 2 1948

Registration District No. _____

Primary Registration District No. 3000

Registrar's No. 160

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

1. PLACE OF DEATH:

(a) County Adair

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

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

(d) Length of stay: In hospital or institution 2 days
(Specify whether _____)

In this community Life
years, months or days

3. (a) PRINT FULL NAME HORACE DEE SHEPARD

3. (b) If veteran, name war U

3. (c) Social Security No. U

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife Emma Shepard

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased 11 21 1878
(Month) (Day) (Year)

8. AGE: Years 69 Months 6 Days 2
If less than one day _____ hr. _____ min.

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

10. Usual occupation Poultry Produce Operator

11. Industry or business _____

12. Name W.W. Shepard

13. Birthplace Upper Sandusky Ohio
(City, town, or county) (State or foreign country)

14. Maiden name Mary Cook

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

16. (a) Informant Arthur D. Shepard

(b) Address 6805 W. 29 Ave - Denver, Colo

17. (a) Burial (b) Date thereof 5 26 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Castle Mo.

18. (a) Signature of funeral director Wm. E. Lambert

(b) Address Green Castle Mo.

19. (a) 5-27-48 (b) Wm. E. Lambert
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Sullivan 105

(c) City or town Green Castle
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 23
year 1948 hour one minute 15 P.M.

21. I hereby certify that I attended the deceased from May 21 1948 to May 23 1948
that I last saw him alive on May 23 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Congestive Heart failure
Lobar Pneumonia 5 days

Due to _____

Due to _____

Other conditions Rheumatic heart disease
(include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy 110

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)

(b) Means of injury 2 DO.

23. Signature T.J. Rhoads
Address Kirksville, Mo Date signed _____

OCT 25 1948

RECEIVED
District Health Office No. 74
District File No. JUN-1-1948
Date Filed

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 Glen E. Kent

Licensed Embalmer No. 1769

P. O. Address Green City 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.