

FILED APR 26 1954

STANDARD CERTIFICATE OF DEATH

State File No. **14103**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3307**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) Life		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Infirmary		e. STREET ADDRESS (If rural, give location) 4471 West Belle Place ²¹¹⁹	

3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) Shepherd c. (Last) Shepherd			4. DATE OF DEATH (Month) (Day) (Year) April 11, 1954		
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5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Aug. 28, 1881		9. AGE (In years last birthday) 72		IF UNDER 1 YEAR Months 7 Days 13		IF UNDER 24 HRS. Hours Min. 	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Postal Clerk		10b. KIND OF BUSINESS OR INDUSTRY U. S. P. O.		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
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13a. FATHER'S NAME John W. Shepherd		13b. MOTHER'S MAIDEN NAME Fannie (?)		14. NAME OF HUSBAND OR WIFE Laurinda Shepherd			
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Laurinda Shepherd, 4471 W. Belle			
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adenocarcinoma of prostate						2 yrs 4 mos	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.							
		DUE TO (b)							
		DUE TO (c)							
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							

19a. DATE OF OPERATION 12-29-51		19b. MAJOR FINDINGS OF OPERATION (carcinoma) Transurethral biopsy of prostate - orchidectomy				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) 177X		(COUNTY)		(STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
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22. I hereby certify that I attended the deceased from 12-1, 1951, to 4-11, 1954, that I last saw the deceased alive on 4-11-54, 1954, and that death occurred at 9:42 p.m., from the causes and on the date stated above.

22a. SIGNATURE Edward B. Williams M.D. (Degree or title)		22b. ADDRESS 4276 Eastern St. Louis		22c. DATE SIGNED 4-13-54	
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 4/14/54		23c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.		23d. LOCATION (City, town, or county) St. Louis County, Missouri		(State)	
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DATE REC'D BY LOCAL REG. APR 14 1954		REGISTRAR'S SIGNATURE Charles J. Gatas		25. FUNERAL DIRECTOR'S SIGNATURE Charles J. Gatas, 4107 Finney Ave.		ADDRESS	
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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, Student Embalmer No.....

working under my personal supervision..

Student.....

Signature of Student Embalmer

Signed *Arthur L. Belliard*.....

Licensed Embalmer No..... 4221

P. O. Address... 4107 Finney

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.