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

FILED APR 4 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8764

BIRTH NO. _____ REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 3040 Registrar's No. 72

1. PLACE OF DEATH
a. COUNTY Livingston
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Chillicothe, Mo.
c. LENGTH OF STAY (in this place) 9yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) At Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY Livingston
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Chillicothe, Mo 0592
d. STREET ADDRESS (If rural, give location) 511 Webster

3. NAME OF DECEASED (Type or Print)
a. (First) SARAH
b. (Middle) CATHRINE
c. (Last) SHEPHERD

4. DATE OF DEATH (Month) March (Day) 26 (Year) 55

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Nov. 23, 1880
9. AGE (In years last birthday) 74 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (City and State or Foreign Country) Tennessee
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Nathan B. Smith
13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE William

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. None
17. INFORMANT'S SIGNATURE OR NAME William Shepherd — ADDRESS

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 wks

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 — Arteriosclerosis — 5 yrs

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 4201
20. AUTOPSY? YES ☐ NO ☒

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) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Mar 17, 1955, *to* Mar 26, 1955 *that I last saw the deceased alive on* Mar 26, 1955, *and that death occurred at* 11 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE G W Carpenter
(Degree or title) MD
23b. ADDRESS Chillicothe Mo
23c. DATE SIGNED 3-28-1955

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 3/29/55
24c. NAME OF CEMETERY ~~OR CREMATORY~~ Edgewood
24d. LOCATION (City, town, or county) Chillicothe, Missouri. (State)

DATE REC'D BY LOCAL REG. 3/28/55
REGISTRAR'S SIGNATURE Frances B Neill
25. FUNERAL DIRECTOR'S SIGNATURE Donald Gordan — ADDRESS Chillicothe Mo.

(Licensed Embalmer's Statement on Reverse Side)

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 .....
Student Embalmer

Signed Richard W. Bandal

Licensed Embalmer No. 4866

P. O. Address Chillicothe,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

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