

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 28 1957

STATE FILE NUMBER

Registration District No. 290 Primary Registration District No. 4427 Registrar's No. 109

1. PLACE OF DEATH a. COUNTY <u>Pulaski</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pulaski</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Waynesville, Mo.</u> Inside Limits? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Waynesville, Mo.</u> Inside Limits? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Way. Gen. Hosp.</u> Length of stay in lb <u>8 days.</u>		d. STREET ADDRESS <u>None.</u> (If outside, give location) <input checked="" type="checkbox"/> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Andrew</u> Last <u>Sheppard.</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>22</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 27, 1884</u>	9. AGE (In years last birthday) <u>73</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	11. BIRTHPLACE (City and state or country) <u>Dixon, Mo. Pulaski Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John W. Sheppard.</u>			14. MOTHER'S MAIDEN NAME <u>Addie Carden</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None.</u>	17. INFORMANT <u>Ora Sheppard</u> Address <u>Waynesville, Mo</u>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Cardiovascular disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4201</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____		

21. I attended the deceased from _____ to Sept and last saw him alive on 8-22-57
Death occurred at 10:00 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>H. E. Nichol, D.D.</u>	22b. ADDRESS <u>Waynesville, Mo.</u>	22c. DATE SIGNED <u>8/23/57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/24/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Buckhorn Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Waynesville, Mo Rural</u>
24. FUNERAL HOME ADDRESS <u>Hedges Funeral Home Waynesville, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>8-24-57</u>	26. REGISTRAR'S SIGNATURE <u>Ora Sheppard</u>

(Licensed Embalmer's Statement on Reverse Side)

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diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
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Date Filed 8-24-57

File Number 109

Pulaski County Health Officer

RECEIVED 8-24-57

DEC 3 1957

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by, Student Embalmer No.....

working under my personal supervision...

Student.....
Signature of Student Embalmer

Signed *Clarence Moore*

Licensed Embalmer No. 488

P. O. Address *Wynnsvi*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. to comply with the above constitute's 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.