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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 58-010186

FILED MAR 19 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1114

1. PLACE OF DEATH
a. COUNTY JACKSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6617 E. 17th ST. — Length of stay in 1b: 1 YEAR

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY JACKSON
c. CITY OR TOWN KANSAS CITY — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 6617 E 17th ST. — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First HOMER Middle — Last SHEPARD

4. DATE OF DEATH Month FEB Day 27 Year 1958

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH APRIL 27, 1878

9. AGE (In years last birthday) 79 — 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) RETIRED CARPENTER

10b. KIND OF BUSINESS OR INDUSTRY BUILDING

11. BIRTHPLACE (City and state or country) GALLATIN, MO

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME OLIVER SHEPARD

13b. MOTHER'S MAIDEN NAME —

14. NAME OF HUSBAND OR WIFE —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. NONE

17. INFORMANT WILLIAM SHEPARD, Address KANSAS CITY, MO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cerebral Hemorrhage — 1 yr
DUE TO (c) Hypertension — 3 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized Arteriosclerosis 331X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 Feb 1 1958, to Feb 26-58 and last saw him alive on Feb 26 1958
Death occurred at 6 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE John M Powers (Degree or title) MD

22b. ADDRESS 3304 Linwood

22c. DATE SIGNED 3/1/58

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

23b. DATE 3-1-58

23c. NAME OF CEMETERY OR CREMATORY CROWN HILL

23d. LOCATION (City, town, or county) EXCELSIOR SPRINGS (State) MO

24. FUNERAL DIRECTOR Prichard Funeral Home, Inc. ADDRESS Excelsior Springs, Missouri

25. DATE RECD. BY LOCAL REG. 3-1-58

26. REGISTRAR'S SIGNATURE Neva Marshall

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

John M. Powers

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 Ralph Van Landingham

Licensed Embalmer No. H.a.o.9

P. O. Address Chelsea Springs, Mi

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.