

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-019112

2420 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2420

FILED MAY 31 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
EMERY R. CELLOWICH

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY Jackson		a. STATE Mo. b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Lee's Summit	
Length of stay in lb 4 Years		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Linderman Nursing Home		d. STREET ADDRESS (If outside, give location) 408 West 3rd Street	
3. NAME OF DECEASED (Type or print) Lillian Cochran Sheppard		4. DATE OF DEATH May 1 1962	
5. SEX Female		6. COLOR OR RACE White	
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 7/2/1873	
9. AGE (last birthday) 88		IF UNDER 1 YEAR Months Days IF UNDER 24 HR 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 Home	
11. BIRTHPLACE (City and state or country) Booneville Mo.		12. CITIZEN OF WHAT COUNTRY U S A	
13a. FATHER'S NAME John Cochran		13b. MOTHER'S MAIDEN NAME Mary E. Brown	
14. NAME OF HUSBAND OR WIFE Deceased		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 John B. Fariss Kansas City Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Cerebral Vascular Accident		5 Minutes	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertensive Cardiovascular Disease		Years	
DUE TO (c) Atherosclerosis Generalized		Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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 a.m. p.m. Month, Day, Year	
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 Oct 8, 1957 to present and last saw her alive on July 7, 1961			
Death occurred at 12:05 A m on the date stated above, and to the best of my knowledge, from the causes stated.			
21a. SIGNATURE Emery R. Calverly MD		22b. ADDRESS 4620 J C Nichols	
22c. DATE SIGNED 5/2/62		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
23b. DATE 5/4/1962		23c. NAME OF CEMETERY OR CREMATORY Lee's Summit Cemetery	
23d. LOCATION (City, town, or county) Lee's Summit Mo.		23e. LOCATION (State) (State)	
24. FUNERAL DIRECTOR Langsford Funeral Home		25. DATE RECD. BY LOCAL REG. 5-3-62	
ADDRESS Lee's Summit Mo.		26. REGISTRAR'S SIGNATURE Ruth Long	

USE BLACK INK OR TYPEWRITER RIBBON

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

M. B. Longford

Licensed Embalmer No. 3893

P. O. Address

Leis Summit

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.