MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1152 2

File No. ____

Registered No. 32

1. PLACE OF DEATH
County: Jackson — Registration District No. 398
Township: Blue — Primary Registration District No. 5554
City: Harrisburg Station, K.C. Mo. (Hospital, St., Ward)

2. FULL NAME: Ethelgualine Shields
(a) Residence. No. 551 Tennessee St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U.S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fe
4. COLOR OR RACE: Wh.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Child

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Child

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Oct. 25 1930

7. AGE

Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	2	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child.
(b) General nature of industry, business, or establishment in which employed (or employer): none
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN): K.C.
(STATE OR COUNTRY): Mo.

PARENTS
10. NAME OF FATHER: Fred J. Shields
11. BIRTHPLACE OF FATHER (CITY OR TOWN): K.C.
(STATE OR COUNTRY): Kansas
12. MAIDEN NAME OF MOTHER: Florence Norgren
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): ____
(STATE OR COUNTRY): New York

14. INFORMANT: Fred J. Shields
(Address): 551 Tennessee

15. FILED: Jan 20, 1931 — Dr. Cook, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan 20 1931

17. I HEREBY CERTIFY, That I attended deceased from January 19, 1931 to Jan. 19, 1931, that I last saw h. alive on Jan. 19, 1931, and that death occurred, on the date stated above, at 3 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho-pneumonia
(duration) ____ yrs. ____ mos. 3 ds.

CONTRIBUTORY (SECONDARY): Probably from exposure
(duration) ____ yrs. ____ mos. ____ ds.

18. WHERE WAS DISEASE CONTRACTED? Home
IF NOT AT PLACE OF DEATH? ____
DID AN OPERATION PRECEDE DEATH? No. DATE OF ____
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) T. T. Martin, M. D.
Jan 20, 1931 (Address) 5 Mt Washington Island

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Mt. Washington — DATE OF BURIAL: Jan 22 1931

20. UNDERTAKER: Mo. C. L. Forstus — ADDRESS: K.C. Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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