

**FILED MAR 11 1940**

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **950**

**1. PLACE OF DEATH:**

(a) County **Jackson**  
(b) City or town **Kansas City**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**3627 White**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **40 yrs.** (Specify whether years, months or days)

8. (a) PRINT FULL NAME **Anna C. Shields**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Fe** 5. Color or race **Col** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **John B. Shields** 6. (c) Age of husband or wife if alive **63** years

7. Birth date of deceased **November 4 1876**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**63 3 22** hr. min.

9. Birthplace **Lexington Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

12. Name **Joe Hawkins**

13. Birthplace **Unknown**  
(City, town, or county) (State or foreign country)

14. Maiden name **Nancy**  
15. Birthplace **Unknown**  
(City, town, or county) (State or foreign country)

16. (a) Informant **John B. Shields**  
(b) Address **3627 White**

17. (a) **burial** (b) Date thereof **3-1-40**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Highland Lincoln**

18. (a) Signature of funeral director **Mathias Bros.**  
(b) Address **1729 Lydia**

19. (a) **2-29-40** (b) **M. M. Browne**  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Missouri** (b) County **Jackson**  
(c) City or town **Kansas City**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **3627 White** (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **Feb.** day **26**  
year **1940** hour **6** minute **A.** M.

21. I hereby certify that I attended the deceased from **Feb 25**  
19**40**, to **Feb 26** 19**40**.

that I last saw her alive on **Feb 25** 19**40**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Lobar Pneumonia**  
Duration **1 1/2**

Due to **10 0**

Due to \_\_\_\_\_

Other conditions **Bronchitis**  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature **B. J. Guggenheims M.D.** (Physician's signature)  
Address **2202 E 18th** Date signed **2/27/40**

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

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

**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 \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. 3994

P. O. Address 1130 E. 23rd St.

**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 this body is not embalmed, above space should be left blank.**