

1 X1981

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.

Registration District No. 508

Primary Registration District No. 3026

1. PLACE OF DEATH:

(a) County Livingston

(b) City or town Chillicothe
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Chillicothe Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Mary Ellen Shields 432

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex. Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife E. F. Shields (d)

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 4th 1879
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>60</u>	<u>11</u>	<u>5</u>	hr. _____ min. _____

9. Birthplace Unknown Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name Charles H. Gilliland

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

14. Maiden name Elizabeth Somes

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

16. (a) Informant's own signature Roy Shields

(b) Address R. R. #1 Ludlow, Missouri

17. (a) Burial (b) Date thereof 6-10-'40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Monroe Cem.

18. (a) Signature of funeral director F. B. Norman

(b) Address Chillicothe, Mo.

19. (a) June 11-1940 (b) Norman M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. 3 miles N.E. Ludlow, Mo.
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 9 year 1940 hour 6 minute 45 P.M.

21. I hereby certify that I attended the deceased from June 8 1940 to June 9 1940, that I last saw her alive on June 9 and that death occurred on the date and hour stated above.

Immediate cause of death Heart decompensation

Due to chronic myocarditis

Due to chronic Bright's disease

Other conditions (Include pregnancy within 3 months of death) 121

Major findings: Of operations _____

Of autopsy None made

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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 R. B. Norman (M. D. or other) _____
Address Chillicothe, Mo. Date signed 6/11/40

RECEIVED

District Health Officer No. 11,

District File Number 740-1171

Date Filed JUL 9 1940

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.....

Elton F. Norman & E. R. Norman (2374)....., Registered Apprentice No.....

working under my personal supervision.

Signed..... Elton F. Norman.....

Licensed Embalmer No. 4036

P. O. Address Chillicothe, Mo.

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.