

FILED JAN 5 1945  
318  
Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

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

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town city of St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Alexian Bros. Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. Recent Bowler  
In this community life 0 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Mad  
(c) City or town city of St. Louis (If outside city or town limits, write "RURAL") 24  
(d) Street No. Alexian Bros. Hospital  
3933 S. Vandeventer  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME John Shields  
3. (b) If veteran, name war none  
3. (c) Social Security No. none

4. Sex male 5. Color or race white  
6. (a) Single, widowed, married, divorced single  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years (Day) (Year)

7. Birth date of deceased July 1866  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>abt</u>	<u>78</u>	<u>5</u>	<u>?</u>	hr. min.

9. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)  
10. Usual occupation retired police officer

11. Industry or business \_\_\_\_\_  
12. Name Thomas Shields  
13. Birthplace Ireland  
(City, town, or county) (State or foreign country)  
14. Maiden name Winifred Shields  
15. Birthplace Ireland  
(City, town, or county) (State or foreign country)

16. (a) Informant James Shields  
(b) Address 4932 Madel  
17. (a) burial (b) Date thereof 1-2-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mt. Olive Cemetery

18. (a) Signature of funeral director Southern Funeral Home  
(b) Address 6322 So. Grand Blvd.

19. (a) DEC 29 1944 (b) J. Baedek  
(Date received last report) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec day 28  
year 1944 hour 5:20 minute 9 M.  
21. I hereby certify that I attended the deceased from March  
11, 1943, to 12-28, 1944  
that I last saw him alive on 12-27-44, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Gr. Myocarditis  
Coronary Sclerosis  
Arterio Sclerosis  
Cerebral Sclerosis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) 92

Major findings of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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)  
(c) Means of injury \_\_\_\_\_  
23. Signature J. Hayden (M. D. or other) MD  
Address 5899 Delmar Date signed 12/29/44

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**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..... *Virgil L. Beattyman*.....  
Licensed Embalmer No..... *4018*.....  
P. O. Address..... *St. Louis 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, fact should be so stated above.**