

FILED MAY 19 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17274

Registrar's No. 26

Registration District No. 148

Primary Registration District No. 3024

1. PLACE OF DEATH:

(a) County Howard
(b) City or town Fayette
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Leas Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
(Specify whether
In this community Since 1938
years, months or days)

3. (a) PRINT FULL NAME Dr Romie B. Shields

3. (b) If veteran, name war -- 3. (c) Social Security No. ---

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife --- 6. (c) Age of husband or wife if alive, --- years

7. Birth date of deceased June 28, 1881
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 10 5 hr. -- min.

9. Birthplace Howard Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Dentist

11. Industry or business ---

MOTHER FATHER
12. Name Henry C. Shields
13. Birthplace Warren Co. Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Shields
15. Birthplace Howard Co. Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Bernard Shields
(b) Address Fayette, Missouri

17. (a) Burial (b) Date thereof 5/5/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director Ralph A. Carr
(b) Address Fayette, Missouri

19. (a) 5-10-1947 (b) Dorothy J. ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howard
(c) City or town Fayette
(If outside city or town limits, write "RURAL")
(d) Street No. ---
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ---

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 3rd
year 1947 hour 8:00 minute P. M.

21. I hereby certify that I attended the deceased from 1938
to May 3, 1947
that I last saw him alive on May 3, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Acute cardiac failure

Due to Coronary disease

Due to ---

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: Of operations none
Of autopsy none

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 [Signature] (M. D. or other) M.D.
Address Fayette, Mo. Date signed 5-6-47

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

RECEIVED
District Health Officer No. 8,
District File Number _____
Date Filed 5-16-47

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 _____,
Lloyd O Jaspering, Registered Apprentice No. 461
working under my personal supervision.

Signed Ralph A Carr
Licensed Embalmer No. 3340
P. O. Address Fayette 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.