No. 300
10-47
17-39
13906

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED DEC 27 1948

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 39879

Registration District No. 12-1-128

Primary Registration District No. 5459 2000

Registrar's No. 37

1. PLACE OF DEATH:

(a) County: Greene Springfield

(b) City or town: ~~Bois D'-Arc Rural Rt. 1~~
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution 2 Weeks (Specify whether years, months or days)

In this community Lifetime

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Greene 39

(c) City or town: Rural Rt.1, Boise D' Arc.
(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

3. (a) PRINT FULL NAME: Mrs. Iva May Shields

3. (b) If veteran, name war: None

3. (c) Social Security No.: None

4. Sex: F.M. 1

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Thomas Franklin Shields

6. (c) Age of husband or wife if alive: 55 years

7. Birth date of deceased: April (Month) 10 (Day) 1886 (Year)

8. AGE: Years 62 Months 8 Days 6 If less than one day hr. min.

9. Birthplace: Rt.1 Boise D' Arc, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation: House wife.

11. Industry or business:

MOTHER FATHER

12. Name: Rudolph Spoon

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

14. Maiden name: Iva Spoon

15. Birthplace: Boise D' Arc, Mo. (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Fern Augustine

(b) Address: Rt.1. Boise D' Arc, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec.18,1948 (Month) (Day) (Year)

(c) Place: burial or cremation: Clear Creek,

18. (a) Signature of funeral director: W.L.Dunn

(b) Address: Springfield, Mo.

19. (a) 12-17-48 (Date received local registrar) (b) Irene Wilson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 16 th. year 1948 hour 11 minute -- A M.

21. I hereby certify that I attended the deceased from 12-1, 1948, to 12-16, 1948; that I last saw her alive on 12-16, 1948; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Uremia	5 days.
Due to: Liver damage from Hepatitis	
Due to: 126	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations: Multiple Gallstones, one large one in Common Bile duct.

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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: [illegible] (M. D. or other)

Address: Springfield Mo. Date signed 12-17-48

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
Greene County Health Office
County File Number 48-12-85
Date Filed 12-24-48

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 H L McCann

Licensed Embalmer No. 2727

P. O. Address Springfield 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.

No. 300
10.48

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39879

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY: Greene
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Springfield
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Burge Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
d. STREET ADDRESS (If rural, give location)

*3. NAME OF DECEASED (Type or Print) a. (First) b. (Middle) c. (Last)

4. DATE OF DEATH (Month) (Day) (Year)

5. SEX

6. COLOR OR RACE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday) If under 1 year Months Days If under 1 day Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME

13b. MOTHER'S MAIDEN NAME

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S SIGNATURE OR NAME ADDRESS

SUPPLEMENTARY

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)

23b. ADDRESS

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. 2/6/49

REGISTRAR'S SIGNATURE Irene H. Wilson

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS

S-39879

No. 300
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39879

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY: Greene
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Springfield
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Burge Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: Greene
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Rt 1 - Boise O'Arc
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Ina b. (Middle) May c. (Last) Shields

4. DATE OF DEATH (Month) (Day) (Year): 12 - 16 - 48

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: 4-10-86
9. AGE (In years last birthday): 62 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Mo
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME: Rudolph Spoon
13b. MOTHER'S MAIDEN NAME: Ina Spoon
14. NAME OF HUSBAND OR WIFE: Thomas Franklin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Mrs Fern Augustine

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Liver damaged from
DUE TO (c) Hepatitis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: Multiple Gallstones one large one in common duct.
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)
23b. ADDRESS
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify)
24b. DATE
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG.: 3/4/49
REGISTRAR'S SIGNATURE: M E Handley MD
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS

SUPPLEMENTARY

S-39879