

FILED JUN 25 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19712

2557

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN HICKMAN MILLS RURAL	
c. LENGTH OF STAY (in this place) 10 YEARS		d. STREET ADDRESS (If rural, give location) 79th + GREENDALE R. R. #2	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOSEPH HOSPITAL			

3. NAME OF DECEASED a. (First) SOPHIA		b. (Middle) JANE		c. (Last) O'BRIEN		4. DATE OF DEATH (Month) (Day) (Year) JUNE-10-1949	
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5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		8. DATE OF BIRTH MAY-16-1869		9. AGE (in years last birthday) 88 YEARS		IF UNDER 1 YEAR Months Days		IF UNDER 1 HR. Hours Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BROOKLYN, IOWA				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
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13a. FATHER'S NAME THOMAS SHIELDS		13b. MOTHER'S MAIDEN NAME PRISCILLA LANDERS		14. NAME OF HUSBAND OR WIFE --	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME ADDRESS MRS. C. W. WOOD 79th + GREENDALE HICKMAN MILLS, MO.			
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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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive cardiac failure						INTERVAL BETWEEN ONSET AND DEATH 3 days	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Cardiovascular disease						3 yrs	
		DUE TO (c) 4221							
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Fracture of leg on 30 May 1949							

19a. DATE OF OPERATION 2 June '49		19b. MAJOR FINDINGS OF OPERATION Fracture left femur				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) accidental injury		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Hickman Mills Rt 2 Jackson Missouri	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) May 30 1949 9a.m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Fell down steps	

22. I hereby certify that I attended the deceased from 30 May, 1949, to 9 June, 1949, that I last saw the deceased alive on 9 June, 1949, and that death occurred at 2:00 a.m., from the causes and on the date stated above.

23a. SIGNATURE Paul G. Goerner (Degree or title) M.D.		23b. ADDRESS Parktown Mo		23c. DATE SIGNED 10 June '49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE JUNE-13-1949		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) HUTCHINSON, KANSAS	
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DATE REC'D BY LOCAL REG. 6-13-49		REGISTRAR'S SIGNATURE Geraldine Holmes		25 FUNERAL DIRECTOR'S SIGNATURE ADDRESS O.W. Newcomer's Sons 1331 BRUSH CREEK KANSAS CITY, MO.	
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(Licensed Embalmer's Statement on Reverse Side)

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

482

1:30-5-

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *D. J. Nofsinger*

Licensed Embalmer No. *3938*

P. O. Address *Kansas City, 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.