

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **7562**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN		c. CITY OR TOWN		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. LENGTH OF STAY (in this place) 2-WKS.		e. STREET ADDRESS (If rural, give location)			
d. FULL NAME OF HOSPITAL OR INSTITUTION					
St. John's Hospital		7326 Dorset Ave.			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First)	b. (Middle)	c. (Last)	(Month)	(Day)	(Year)
Katherine	A.	Shields	Aug.	16,	1954
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
F.	W.	S.	June 13, 1865	89	IF UNDER 1 YEAR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country)	12. CITIZEN OF WHAT COUNTRY?	
Retired Sales Lady, S.V. Barney			St. Louis, Mo.	U.S.	

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
Joseph Shields	Catherine Moore	
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
no	491-14-4071	Mrs. Dorothy Shasserre, 7326 Dorset Ave.

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2-3 wks
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		
	Bronchial Pneumonia		
	ANTECEDENT CAUSES		
	Morbid conditions, if any, giving rise to the above cause (a) dating 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.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT (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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 191X

22. I hereby certify that I attended the deceased from Aug 1, 1954, to Aug 16, 1954, that I last saw the deceased alive on Aug 14, 1954, and that death occurred at 1:30 am, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Irvin A. Munsch M.D.	33 N. Meramec Clayton Mo	8-16-54
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY
Burial	Aug. 18, 1954	Calvary Cemetery
		24d. LOCATION (City, town, or county) (State)
		St. Louis, Mo.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
AUG 16 1954	J. Earl Smith	Walter J. Donnelly	3840 Lindell Blvd.

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

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.....
Signature of Student Embalmer

Signed *Francis Williamson*

Licensed Embalmer No. *356*

P. O. Address *3840 Le...*

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 embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.
If this body is not embalmed, fact should be so stated above.