

FILED NOV 30 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

37835

No. 200
10.48

BIRTH NO. _____		REG. DIST. NO. <u>164</u>		PRIMARY REG. DIST. NO. <u>3032</u>		Registrar's No. <u>146</u>	
1. PLACE OF DEATH a. COUNTY <u>Johnson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Johnson</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Warrensburg</u>		c. LENGTH OF STAY (in this place) <u>1 Day</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Chilhowee</u>		610	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Warrensburg Medical Center</u>				d. STREET ADDRESS (If rural, give location) <u>0</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Peter</u>			b. (Middle)			c. (Last) <u>Shields</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 14, 1954</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>July 7, 1886</u>	
9. AGE (in years last birthday) <u>68</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grain & Stock</u>		11. BIRTHPLACE (City and State or Foreign Country) / <u>Indiana</u>	
12. CITIZEN OF WHAT COUNTRY <u>U S A</u>		13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Sarah Shields</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Clara McElwee, Chilhowee, Mo.</u>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Fracture rt. hip + acetabulum 1 day</u> ANTECEDENT CAUSES DUE TO (b) <u>Generalized Arteriosclerosis</u> <u>1 yr</u> <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (c) <u>Cerebral Arteriosclerosis with mental confusion</u> <u>3 months</u> II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> <u>E9620</u> <u>21</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT <u>SHOULDER</u> <u>HOMICIDE</u> (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) <u>051</u> (STATE) <u>Warrensburg Mo Johnson Mo</u>			
21d. TIME OF INJURY <u>Nov. 13 1954 2:29</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell from 2nd story window</u>			
22. I hereby certify that I attended the deceased from <u>Aug 1, 1954</u> , to <u>11-14, 1954</u> , that I last saw the deceased alive on <u>11-13, 1954</u> , and that death occurred at <u>10:05 P. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Name) <u>R. Lee Cooper, M.D.</u> (Degree or title)				23b. ADDRESS <u>Warrensburg Mo</u>		23c. DATE SIGNED <u>11-15-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Nov. 16, 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Pisgah</u>		24d. LOCATION (City, town, or county) (State) <u>Johnson County, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>Nov 15, 1954</u>		REGISTRAR'S SIGNATURE <u>Savannah Whitefield</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Cook Funeral Home, Chilhowee, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
NOV 22 1954
JOHNSON COUNTY HEALTH DEPT.

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

John P. Rodgers

Licensed Embalmer No. 4963

P. O. Address Wentzelsburg, Ind.

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.