

FILED JUL 8 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18967**
2736

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>2736</u>		
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)				
a. COUNTY Jackson		a. STATE Kansas		b. COUNTY Franklin				
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City, Mo		c. LENGTH OF STAY (In this place) 2 Weeks		c. CITY OR TOWN Ottawa		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION RESEARCH HOSPITAL				e. STREET ADDRESS (If rural, give location) 709 East 5th St.				
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH					
a. (First) Raymond		b. (Middle) Shields		c. (Last) Shields		4. DATE OF DEATH (Month) (Day) (Year) 6 25 55		
5. SEX M		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Dec. 1, 1903		
9. AGE (In years last birthday) 51		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) Implement Dealer			10b. KIND OF BUSINESS OR INDUSTRY Distributor			11. BIRTHPLACE (City and State or Foreign Country) Wellsville, Kansas		
12. CITIZEN OF WHAT COUNTRY? USA			13a. FATHER'S NAME Byron Shields		13b. MOTHER'S MAIDEN NAME Maude Dixon		14. NAME OF HUSBAND OR WIFE Leone B. Shields	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) none		16. SOCIAL SECURITY NO. not available		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Leone B. Shields Ottawa, Kansas				
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH		
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Glioblastoma multiforme - rt. Tempore/ lobe				6 mos.		
		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.				193h		
19a. DATE OF OPERATION 6-25-55		19b. MAJOR FINDINGS OF OPERATION Tumor as above				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I, hereby certify that I attended the deceased from <u>6-23-55</u> , 19 <u>55</u> , to <u>6-25-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6-25-55</u> , 19 <u>55</u> , and that death occurred at <u>2:30 p.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE La Rue Wiley (Degree or title) M.D.				23b. ADDRESS 411 Nichols Rd. K.C. Mo.		23c. DATE SIGNED 6-25-55		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE June 27, 1955		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) Ottawa Kansas		
DATE REC'D BY LOCAL REG. 6-27-55		REGISTRAR'S SIGNATURE Neva Marshall		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS R.A. Fulton Kansas City, Kansas				

WRITE PLAINLY—USING UNFADING 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.....
[Handwritten Signature]

Licensed Embalmer No. *303*

P. O. Address.....
[Handwritten Address]

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.