

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-002011

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 600 STATE FILE NUMBER

FEB 15 1962

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Platte</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in lb <u>12 da</u>	c. CITY OR TOWN <u>Parkerille Mo</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Joseph</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R-1 Bx 405</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Lena</u> Middle <u>Senora</u> Last <u>Shields</u>			4. DATE OF DEATH <u>Jan 31-1962</u> Month <u>Jan</u> Day <u>31</u> Year <u>1962</u>	
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4/29/91</u>	9. AGE (last birthday) <u>70</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>housekeeper</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (City and state or country) <u>Parkerille Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA.</u>
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13. FATHER'S NAME <u>James T Shields</u>	13b. MOTHER'S MAIDEN NAME <u>May Fleming</u>	14. NAME OF HUSBAND OR WIFE <u>Arthur Shields</u> Deceased
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT <u>Harold Shields</u> Address <u>Parkerille Mo</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia, chronic</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Carcinoma of lung, metastatic</u>		<u>6 months</u>
DUE TO (c) <u>Primary Carcinoma, site unknown</u>		<u>?</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <u> </u> s.m. <u> </u> p.m. <u> </u>	Month, Day, Year <u> </u> <u> </u> <u> </u>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from: 11-27-61 to 1-31-62 and last saw her live on 1-31-62
 Death occurred at 3:50 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Charles L. Cooper MD</u> (Degree or title)	22b. ADDRESS <u>618 Poplarwood Blvd K.C. Mo</u>	22c. DATE SIGNED <u>2-1-62</u>
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23a. BURIAL, CREMATION, OR REMOVAL (Specify)	23b. DATE <u>Feb 3-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Walnut Grove</u>	23d. LOCATION (City, town, or county) (State) <u>Parkerille Mo</u>
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24. FUNERAL DIRECTOR <u>Ieland H. Francis</u> ADDRESS <u>Parkerille</u>	25. DATE RECD. BY LOCAL REG. <u>2-1-62</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 Charles S/ Cooper
 ITEM NO. SHOULD READ

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 Leland H. Francis

Licensed Embalmer No. 3451

P. O. Address Parkville, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.