MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

30694

1. PLACE OF DEATH
County Jackson — Registration District No. 398 — File No. 1
Township Blue — Primary Registration District No. 3019 — Registered No. 323
City Independence (No. ..... St. ..... Ward)

2. FULL NAME Myrtle Shields.
(a) Residence. No. 721 E Pacific St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE Col
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married.
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Clabe Shields.
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 27-1885
7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
44	1	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Independence
(STATE OR COUNTRY) Mo.

PARENTS
10. NAME OF FATHER Clinton Estes
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mo.
12. MAIDEN NAME OF MOTHER Delala Hudson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mo.

14. INFORMANT Clabe Shields.
(Address) Independence Mo.

15. FILED 9-28, 1929 F L Cook
REGISTRAR

MEDICAL CERTIFICATE OF DEATH 3

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 27 1929
17. I HEREBY CERTIFY, That I attended deceased from Sept 23, 1929, to Sept 27, 1929, that I last saw her alive on Sept 27, 1929, and that death occurred, on the date stated above, at 11 40 a m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Removal of Fibroid Tumor
(duration) ..... yrs. ..... mos. 5 ds.
CONTRIBUTORY (SECONDARY) Acute Peritonitis
(duration) ..... yrs. ..... mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? Yes DATE OF Sept 23-29
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Removal of Tumor Sing. Symptoms
(Signed) S. H. Griffin, M. D
9-28 1929 (Address) Sedalia Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Woodlawn Cem.
DATE OF BURIAL Sept 29 1929
20. UNDERTAKER W. L. Bower & Co
ADDRESS Indep. Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... state ... important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Jackson — Registration District No. 398 — File No.
Township — Primary Registration District No. 3019 — Registered No. 323
City Indep. (No. , St. Ward)

2. FULL NAME Myrtle Shields
(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
O+	Col	M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 11-1, 1929 F. L. Cook
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 27 1929

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 , that I last saw h alive on , 19 , and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Removal of Fibroid tumor of uterus malignant
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

46

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) , M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

WRITE PLAINLY, WITH UNFADING INK

N. B. Item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1929
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