

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

32431
Do not use this space.

1939 OCT 2 1939

1. PLACE OF DEATH
 (a) County..... GREENE Registration District No. 316
 (b) Township..... SPRINGFIELD Primary Registration District No. 2001 Registered No. 726
 (c) City..... SPRINGFIELD (d) Street No. St Johns Hospital St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME SHARON K. SHIELDS.
 (a) Residence, No. 1507 G. Commercial St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 15-1939

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<input checked="" type="checkbox"/>	<u>0</u>	<u>6</u>	<u>14</u>	

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Infant in home
 9. Industry or business in which work was done, as saw mill, bank, etc. In home
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

FATHER
 13. NAME Kenneth L. Shields
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

MOTHER
 15. MAIDEN NAME Emma Suisse
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) Kenneth L. Shields Springfield Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Cremation DATE Oct 1 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. Blumquist Springfield Mo.

20. FILED Sept 30 1939 Chas W. George Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 29 1939

22. I HEREBY CERTIFY, That I attended deceased from 7-11-39, 19, to 9-29-39, 19.....
 I last saw h. or alive on 9-29-39, 19..... Death is said to have occurred on the date stated above, at 3:30 pm.
 The principal cause of death and related causes of importance were as follows:

<u>Bronchial Pneumonia</u>	Date of onset <u>9-27-39</u>
<u>IX M. R</u>	
<u>107</u>	

Other contributory causes of importance:
Ameglotonia Congenita

Name of operation..... Date of.....
 What test confirmed diagnosis? X-ray Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
 If so, specify.....
 (Signed) Luigi Schwartz M. D.
 (Address) 360 West 2nd St. Springfield

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed J.B. Klingner
Licensed Embalmer No. 3358
P. O. 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 this body is not embalmed, above space should be left blank.

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