

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.

REGISTRATION DISTRICT NO. 791

State File No. 37802  
Registrar's No. 9641

1. PLACE OF DEATH: RUUS 2  
(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Chase Hotel  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Dr. Edwin H. Shields 432  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Pauline Rice Shields 6. (c) Age of husband or wife if alive 60 years  
7. Birth date of deceased Jan. 29 1866  
(Month) (Day) (Year)

8. AGE: Years 73 Months 9 Days 12 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Charleston W. Virginia  
(City, town, or county) (State or foreign country)

10. Usual occupation Physician

11. Industry or business \_\_\_\_\_  
12. Name Joseph Shields  
13. Birthplace Germany  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Pauline Shields  
(b) Address Chase Hotel

17. (a) Removal (b) Date thereof Nov. 13-39  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Cincinnati, Ohio

18. (a) Signature of funeral director Herman Finkelsky  
(b) Address 5216 Delmar Blvd.

19. (a) 11-2-39 (b) J. F. Budich  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County 1  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. Chase Hotel 12  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 11  
year 1939 hour 8 minute A. M.  
21. I hereby certify that I attended the deceased from April 30, 1939, to Nov 11, 1939.  
that I last saw him alive on 11/11, 1939.  
and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Pulmonary Edema 12 hours  
Due to arterio-sclerotic and hypertensive heart disease. 9 yrs +  
Due to cut. sclerotic 9 yrs +  
Other conditions: Diabetes Mellitus 5 yrs?  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature Arthur E. Shady (M. D. or other)  
Address 539 N. Grand. Date signed 11/11/39

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**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..... *Charles Cooper* .....

Licensed Embalmer No. **3830** .....

P. O. Address..... *5216 Delmar* .....

**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.**