No. 2
4-13-40
-17-39
X23159

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 37836

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 4434

FILED DEC 1 1940

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City Mo. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Children's Mercy Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11-16-40 6 P.M. to 11-19-40 12 ½ AM (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town North Kansas City (If outside city or town limits, write "RURAL")
(d) Street No. 1203 Swift (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Leona Patricia Shields
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased May (Month) 5 (Day) 1940 (Year)
8. AGE: Years 0 Months 6 Days 16 If less than one day hr. min.
9. Birthplace Kansas City Mo (City, town, or county) (State or foreign country) 0
10. Usual occupation infant 1
11. Industry or business 0
FATHER 12. Name Arthur Roe Shields
13. Birthplace Enid Okla (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Leona Anderson
15. Birthplace Lexington Mo (City, town, or country) (State or foreign country)
16. (a) Informant Arthur Shields
(b) Address 1203 Swift No KC Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-40 (Month) (Day) (Year)
(c) Place: burial or cremation Berry Cem - Clay Co.
18. (a) Signature of funeral director Morton Funeral Home
(b) Address North Kansas City Mo
19. (a) 11-20-40 (Date received local registrar) (b) M. M. Osborne (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 19 year 1940 hour 12 minute 25 A.M.
21. I hereby certify that I attended the deceased from 11-16-40, 1940, to 11-19, 1940; that I last saw h. alive on 11-19, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Lobar pneumonia	4 days
Due to Pneumococcus	
Due to IDS	
Other conditions Acute laryngitis (Include pregnancy within 3 months of death)	

Major findings: Of operations none
Of autopsy none

PHYSICIAN — 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? (Specify type of place)
While at work? (e) Means of injury —
23. Signature Frederic Speer (M. D. or other) MD
Address 2601 Parallel Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No. 3605

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

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