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K23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

5625

State File No.

FILED MAR 16 1942
Registration District No. 229

Primary Registration District No. 1003

Registrar's No. 915

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

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: Lakeside Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 hours
(Specify whether years, months or days)

In this community 7 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. 445 Skiles
(If rural, give location)

(e) If foreign born, how long in U. S. A? 0 years.

3. (a) PRINT FULL NAME Norma Gail Shields

3. (b) If veteran, name war --

3. (c) Social Security No. --

4. Sex F / race W

5. Color or W

6. (a) Single, widowed, married, divorced --

6. (b) Name of husband or wife --

6. (c) Age of husband or wife if alive -- years

7. Birth date of deceased May 14th, 1934
(Month) (Day) (Year)

8. AGE: Years 7 Months 9 Days 21
If less than one day hr. min.

9. Birthplace Kansas City Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation School

11. Industry or business None

MOTHER FATHER {

12. Name Henry M. Shields

13. Birthplace Peoria, Ill
(City, town, or county) (State or foreign country)

14. Maiden name Gladys L. Cupp

15. Birthplace Carthage, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Henry M. Shields

(b) Address 445 Skiles, K.C. Mo.

17. (a) Burial (b) Date thereof Mar. 7th-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hills Cemetery Sheil Funeral Home

18. (a) Signature of funeral director Sheil Funeral Home

(b) Address 6606 Indep. Ave. K.C. Mo.

19. (a) 3/6/42 (b) M. M. Crown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 5th
year 1942 hour 10 minute 0 M.

21. I hereby certify that I attended the deceased from March 4
1942 to March 5 1942
that I last saw her alive on March 5 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Delayed Surgical Shock

Duration 6 hrs.

Due to Appendectomy 2

Due to Acute Gangrenous Appendicitis (Ruptured) 48 hrs

Other conditions 12/1
(Include pregnancy within 3 months of death)

Major findings: Of operations Appendix Gangrenous Ruptured distal end

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? _____

While at work? _____ (Specify type of place)

Means of injury ---

23. Signature George J. Conley (M. D. or other) Do

Address 116 W. 47th K.C. Mo. Date signed March 5/42

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.....

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, fact should be so stated above.