

FILED FEB 4 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1130**
288

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY about 30yrs.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY	
d. FULL NAME OF HOSPITAL OR INSTITUTION TRINITY HOSPITAL		d. STREET ADDRESS (If rural, give location) 7308 WASHINGTON ST.	

3. NAME OF DECEASED (Type or Print) a. (First) SHIELDS	b. (Middle) W.	c. (Last) FAIR	4. DATE OF DEATH (Month) (Day) (Year) JAN 19 1950
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5. SEX MALE	6. COLOR OR RACE White	7. MARRIED NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH NOV. 8, 1873	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 48 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHYSICIAN	10b. KIND OF BUSINESS OR INDUSTRY M. D.	11. BIRTHPLACE (State or foreign country) AVALON, Mo	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Thomas FAIR	13b. MOTHER'S MAIDEN NAME Nancy SHIELDS	14. NAME OF HUSBAND OR WIFE Katherine FAIR
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give way or dates of service) WORLD WAR I	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME Mrs. S. W. FAIR ADDRESS 7308 WASHINGTON K. C. Mo
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc.: It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 4 1/2
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Soudrenal ulcer perforated into pancreas - Pancreatitis		
	ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) Arterio-sclerosis with cerebral oedema		
II. OTHER SIGNIFICANT CONDITIONS: Arterio-sclerosis with cerebral oedema		2 days.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Chronic Duodenal ulcer perforated into pancreas	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Oct 1949**, to **1-19 1950**, that I last saw the deceased alive on **1-19 1950**, and that death occurred at **7:35 A. M.** from the causes and on the date stated above.

23a. SIGNATURE John H. Ogilvie M.D. (Degree or title)	23b. ADDRESS 730 Profit Bldg	23c. DATE SIGNED 1-20-50
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24a. BURIAL CREMATION (REMOVAL) (Specify) BURIAL	24b. DATE JAN. 23, 1950	24c. NAME OF CEMETERY OR CREMATORY BELTON CEMETERY	24d. LOCATION (City, town, or county) (State) Belton Mo.
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DATE REC'D BY LOCAL REG. 1-20-50	REGISTRAR'S SIGNATURE Geraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE E. K. George + Sons ADDRESS Belton Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

FEB 6 1950

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. 5645

P. O. Address Gandwin, Md

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.