

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42605

State File No. _____

FILED NOV 27 1957

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

Registrar's No. **11025**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 11025	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____			
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony's Hospital				e. STREET ADDRESS (If rural, give location) 5949 Loughborough Ave			
3. NAME OF DECEASED (Type or Print) a. (First) JESSE		b. (Middle) E.		c. (Last) SHIELDS		4. DATE OF DEATH (Month) (Day) (Year) 11-17-1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 10-15-1868		9. AGE (In years last birthday) 89	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME William McConnell			13b. MOTHER'S MAIDEN NAME Emma King			14. NAME OF HUSBAND OR WIFE Harry C. Shields (Deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Harry C. Shields 5949 Loughborough Ave			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Acute Coronary Failure		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Acute Coronary Failure				INTERVAL BETWEEN ONSET AND DEATH 2 day	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death Comminuted Fracture of Left Hip - Fracture of Left Shoulder					
19a. DATE OF OPERATION 11/19/57		19b. MAJOR FINDINGS OF OPERATION Left Femur - Inter trochanteric Fracture		20. AUTOPSY? 2		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) E904.021			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Nov. 10 - 1957 4:45 PM		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Fell at home in bedroom			
22. I hereby certify that I attended the deceased from Nov. 10 - 1957 to Nov. 12, 1957 , that I last saw the deceased alive on Nov. 12, 1957 , and that death occurred at 10:00 P. , from the causes and on the date stated above.							
23a. SIGNATURE J. H. [Signature] (Degree or title) MD				23b. ADDRESS 3606 Gravois Ave		23c. DATE SIGNED 11/18/57	
24a. BURIAL, CREMATION REMOVAL (Specify) Removal		24b. DATE 11-19-1957		24c. NAME OF CEMETERY OR CREMATORY Stanhope Union Cemetery		24d. LOCATION (City, town, or county) (State) Monticello N.J. New Jersey	
DATE REC'D BY LOCAL REG. NOV 18 57		REGISTRAR'S SIGNATURE [Signature]		FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS 6409 Gravois Ave	

Dr. Wm. Weinsberg PR 3-2959 3606 Gravois Ave 264
 WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

(Licensed Embalmers' 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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Alan Benz* 4863
Licensed Embalmer No. ~~2087~~ 4863

P. O. Address *Rt 2nd Mo.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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