

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-035719

STATE FILE NUMBER

FILED NOV 10 1958

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 512

300

1-57

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1. PLACE OF DEATH a. COUNTY <u>CAPE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>SCOTT</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CAPE GIRARDEAU</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>CHAFFEE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>HAVEN OF REST NURSING HOME</u>		Length of stay in 1b <u>15 DAYS</u>	d. STREET ADDRESS (If outside, give location) <u>317 N. 5th ST.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE WASHINGTON SHIELDS</u>			4. DATE OF DEATH Month Day Year <u>OCT. 24, 1958</u>		
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 21, 1870</u>	9. AGE (In years last birthday) <u>88</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u>	IF UNDER 24 HRS. Hours <u>3</u> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STATIONARY FIREMAN (RET.)</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>HINDMAN LBR. Co.</u>	11. BIRTHPLACE (City and state or country) <u>Bloomington, Indiana</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>VINCENT SHIELDS</u>	13b. MOTHER'S MAIDEN NAME <u>ELIZABETH WATSON</u>	14. NAME OF HUSBAND OR WIFE <u>MARY JANE SHIELDS</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>MRS GEORGE W. SHIELDS - CHAFFEE, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>medullary Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Chronic bilateral glomerulonephritis</u>	<u>3 years.</u>
	DUE TO (c) <u>prostaticism</u>	<u>610X 5 years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cardio-vascular-renal Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.
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20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <u>8-17-54</u> to <u>10-24-58</u> and last saw her/him alive on <u>10-9-58</u> Death occurred at <u>1:10 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>H. A. Hehmer, D.O. 2</u>	22b. ADDRESS <u>Chaffee, Missouri</u>	22c. DATE SIGNED <u>10/25/58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>OCT. 26, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BOSS CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>ADWANKLE, Mo.</u>
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24. FUNERAL DIRECTOR <u>BISPHINGHOFF FUNERAL HOME</u>	ADDRESS <u>CHAFFEE, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>OCT. 30, 1958</u>	26. REGISTRAR'S SIGNATURE <u>Mr. Homer Cooper</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Information, etc., must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Jack F. Burnett* .....  
Licensed Embalmer No. *4493* .....

P. O. Address *Chaffee, 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.