

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-040769**

FILED VS DEC 1 1959 170 Primary Registration District No. 3033 Registrar's No. 179

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Laclede</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Laclede</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Lebanon</b>		Length of stay in 1b <b>18 Yrs.</b>		c. CITY OR TOWN <b>Lebanon</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>154 N. Lonroe</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>154 No. Monroe</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Bertha E Shields</b>				4. DATE OF DEATH <b>Nov. 17 1959</b>									
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>July 12 1874</b>		9. AGE (last birthday) <b>85</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (City and state or country) <b>Wright Co. Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>					
13a. FATHER'S NAME <b>Hiram D. Bramhall</b>				13b. MOTHER'S MAIDEN NAME <b>Martha Finley</b>				14. NAME OF HUSBAND OR WIFE <b>John S. Shields</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. R. C. Mayfield Lebanon Mo.</b> Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture Left Hip</b>										INTERVAL BETWEEN ONSET AND DEATH <b>8 Dec 59</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerosis Generalized.</b>								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input checked="" 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.) <b>Fell at home &amp; sec 58.</b>									
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. <b>Dec 8, 1959</b>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. CITY, TOWN, OR LOCATION <b>Lebanon</b>		COUNTY <b>Laclede</b>		STATE <b>Mo</b>			
21. I attended the deceased from <b>5-17-1949</b> to <b>11/17/1959</b> and last saw her/him alive on <b>11/17/1959</b> Death occurred at <b>12.30 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <b>Paul A. Justice MD</b>						22b. ADDRESS <b>Knight Blvd. Lebanon. Mo</b>			22c. DATE SIGNED <b>Nov. 23, 1959</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>11/18/59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lebanon City</b>			23d. LOCATION (City, town, or county) (State) <b>Lebanon Mo.</b>					
24. FUNERAL DIRECTOR <b>S. R. Palmer</b>					ADDRESS <b>Lebanon Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>11-23-1959</b>		26. REGISTRAR'S SIGNATURE <b>Mella L. May</b>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DECEMBER 1988

**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 S. R. Palmer

Licensed Embalmer No. 2208  
P. O. Address Lebanon, 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.