

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

APR 30 1930

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

5517

1. PLACE OF DEATH

County Lafayette Registration District No. 460  
Township..... Primary Registration District No. 4274  
City Higginsville St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME John W. Short

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

2. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lilian Short

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mon. 17th 1858

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>71</u>	<u>10</u>	<u>21</u>		

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Carpenter  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) St. Clair Co.  
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER John Short Sr.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY) Missouri.

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY) Unknown

14. INFORMANT Fazel Ward  
(Address) Higginsville, Mo.

15. FILED 2-10 1930 Bessie P Porter  
REGISTRAR

4 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-8-1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 10<sup>th</sup>, 1930, to Feb 8-1-, 1930, that I last saw him alive on Jan 7-7-, 1930, and that death occurred, on the date stated above, at 7.00 AM.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Fracture of Neck of Left Femur  
Right wrist & Prostate gland  
Fracture from fall 2 week prior to death  
Prostate gland (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) Diabetes  
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH: \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical Exam  
(Signed) J. H. [Signature], M. D.  
, 19 (Address) Higginsville, Mo.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL City DATE OF BURIAL 2/9/30 1930

20. UNDERTAKER W. W. [Signature] ADDRESS Higginsville,

