DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 35206

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 4181

1. PLACE OF DEATH: NOV 14 1939
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Kansas City G. Hospt
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 days (Specify whether
In this community 23 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 215½ Indep Ave
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Ben T Short
3. (b) If veteran, name war no
3. (c) Social Security No. no
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced D.
6. (b) Name of husband or wife unknown
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased April (Month) 5 (Day) 1868 (Year)

8. AGE: Years 71 Months 6 Days 24 If less than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) Ind (State or foreign country)
10. Usual occupation none
11. Industry or business
FATHER
12. Name Robert Short
13. Birthplace ..... (City, town, or county) Ohio (State or foreign country)
MOTHER
14. Maiden name Nancy Jackson
15. Birthplace ..... (City, town, or county) Ind (State or foreign country)
16. (a) Informant's own signature Record Clerk
(b) Address KC Gen Hospt
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10 (Month) 31 (Day) 1939 (Year)
(c) Place: burial or cremation Jeffersonville Ind
18. (a) Signature of funeral director M. F. Mayberry
(b) Address Kansas City Mo
19. (a) 10/31/39 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 29 year 1939 hour 2 minute 15-a M.
21. I hereby certify that I attended the deceased from Oct 21, 1939, to Oct 29, 1939 that I last saw him alive on Oct 29-39, 19..; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pernicious Anemia	
Due to	
Due to 71	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy none	

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature P F De Maria M.D. (M. D. or other)
Address Supt KC Gen Hospt Date signed 10-30-39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Rev. 5-17-39 I X19511

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 R. E. Snow, Registered ~~Apprentice~~ Emb No. 2560, working under my personal supervision.

Signed W S Mayberry

Licensed Embalmer No. 2934

P. O. Address

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, above space should be left blank.