

FILED MAY 9 1944
Registration District No. 174

Primary Registration District No. 5644

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Safayette
(b) City or town Rural
(c) Name of hospital or institution: Safayette County Home
(If not in hospital or institution, write street number & location)
(d) Length of stay: In hospital or institution 50 years (Specify whether years, months or days)
In this community 50 years

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Safayette
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Lid SHORT

3. (b) If veteran, name war _____

no

3. (c) Social Security No. _____

no

4. Sex male S. Color or race white

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____

mo - 13 1861
(Month) (Day) (Year)

8. AGE:

Years 82 Months 4 Days 17 If less than one day _____ hr. _____ min.

9. Birthplace _____

Glasgow MO
(City, town, or county) (State or foreign country)

10. Usual occupation _____

miner

11. Industry or business _____

same

MOTHER FATHER
{ 12. Name John Short
13. Birthplace Kentucky
14. Maiden name Maria Brown
15. Birthplace unknown

16. (a) Informant Floyd Short
(b) Address Wellington MO
17. (a) Burial (b) Date thereof 4-2-1944
(burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Wellington Cemetery
18. (a) Signature of funeral director W. H. Green
(b) Address Wellington MO
19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month April day 1
year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Aug 1942 to Apr 5 1944
that I last saw him alive on April 28 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage on leg.

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____
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? _____

While at work _____ (Specify type of place) (e) Means of injury _____
23. Signature W. H. Green (M. D. or other) MD
Address W. H. Green Date signed 4/2/1944

USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 8,

District File Number

5-8-47

Date Filed

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed

W. J. Owen

Licensed Embalmer No. 4305

P. O. Address *McClatchy*

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, fact should be so stated above.

Registration District No. 174 Primary Registration District No. 5644

1. PLACE OF DEATH:

(a) County Lafayette

(b) City or town Rural (If outside city or town limits, write "RURAL" and name of township) Reston

(c) Name of hospital or institution: County Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 5 yrs years, months or days

3. (a) PRINT FULL NAME Gid Short

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased: Nov. 13 1961
(Month) (Day) (Year)

8. AGE: Years 82 Months 4 Days _____ (If less than one day, _____ min.)

9. Birthplace Mo (City, town, or county) (State or foreign country)

10. Usual occupation Miner

11. Industry or business _____

12. Name John

13. Birthplace Key (City, town, or county) (State or foreign country)

14. Maiden name Maria Branston

15. Birthplace Wash (City, town, or county) (State or foreign country)

16. (a) Informant Flora Short

(b) Address Wellington, Mo

17. (a) _____ (b) Date thereof 4-2-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wellington Cemetery

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) May 12-44 (Date received local registrar) (b) Mrs. Fred Schurb (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lafayette

(c) City or town Rural (If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April year 1984 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) 83a

Major findings: Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature W.E. Kasperbink (M. D. or other) _____

Address Wilmington, Mo Date signed 4-2-44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MISSOURI DEPARTMENT OF HEALTH

1941

Box 1

The Southern
States

21051