V. S. No. 2
50M—5-42
Rev. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 24015

FILED AUG 13 1945

Registration District No. 128 Primary Registration District No. 5466 Registrar's No. 567

39 0 0

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town RURAL, S. CAMPBELL TWP.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: OZARK OSTEOPATHIC HOSPITAL 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days (Specify whether years, months or days)

In this community —

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

(c) City or town Republic 0
(If outside city or town limits, write "RURAL")

(d) Street No. — 0
(If rural, give location)

(e) Citizen of foreign country? — (Yes or No) 0

If yes, name country —

3. (a) PRINT FULL NAME Martha Jane Short

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) ~~Single~~, widowed, ~~married~~, ~~divorced~~ Widowed

6. (b) Name of husband or ~~wife~~ William Calvin Short

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

7. Birth date of deceased January (Month) 14 (Day) 1866 (Year)

8. AGE: Years	Months	Days	If less than one day
84	6	7	— hr. — min.

9. Birthplace UNK. (City, town, or county) UNK. 0 (State or foreign country)

10. Usual occupation House-wife.

11. Industry or business —

FATHER
12. Name Peter Anderson
13. Birthplace Unk. Tenn. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unk.
15. Birthplace Unk. (City, town, or county) Unk. 0 (State or foreign country)

16. (a) Informant Mr. Roy B. Short
(b) Address Brookline, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof July 21 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Republic, Mo.

18. (a) Signature of funeral director R. E. Churman Co.
(b) Address Republic, Mo.

19. (a) July 23-1945 (Date received local registrar) (b) E. M. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 21 year 1945 hour 1:06 P.M. minutes M.

21. I hereby certify that I attended the deceased from 7-20- 1945 to 7-21- 1945 that I last saw her alive on 7-21- 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	2 days
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: No	

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 [illegible] M.D.
Address Republic, Mo. Date signed 7-22-45

984 (Licensed Embalmer's Statement on Reverse Side)

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 R. E. Thurman & Co.

Licensed Embalmer No. 503

P. O. Address Republic, 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 this body is not embalmed, fact should be so stated above.