

Registration District No. 145

Primary Registration District No. 5566

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

1. PLACE OF DEATH:

(a) County IRON
(b) City or town EAST END
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 77 yrs. years, months or days

3. (a) PRINT FULL NAME SARAH EMELINE SHORT

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

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

7. Birth date of deceased OCT. 14 - 1869
(Month) (Day) (Year)

8. AGE: Years 77 Months 3 Days 2 If less than one day _____ hr. _____ min.

9. Birthplace CRAWFORD Co. MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business _____

MOTHER FATHER { 12. Name DABNEY MARTIN (D)

13. Birthplace CRAWFORD Co. MISSOURI
(City, town, or county) (State or foreign country)

14. Maiden name RACHEAL REEVES (R)

15. Birthplace CRAWFORD Co. MISSOURI
(City, town, or county) (State or foreign country)

16. (a) Informant DOROTHY EATON

(b) Address STEELVILLE, MO.

17. (a) BURIAL (b) Date thereof 2-18-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation STEELVILLE CEM.

18. (a) Signature of funeral director Thomas J. Hubert

(b) Address STEELVILLE, MISSOURI

19. (a) Mar 1 - 1947 (b) Max Elizabeth Logan
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CRAWFORD ²⁸
(c) City or town STEELVILLE ²
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 1
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB. day 16 TH.
year 1947 hour _____ minute 08 P.M.

21. I hereby certify that I attended the deceased from _____, 1947, to FEB. 16, 1947.
that I last saw h. EV alive on FEB. 16 and that death occurred on the date and hour stated above.

Immediate cause of death DIARRHEA Duration _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 D

23. Signature A H Hgym (M. D. or other) _____

Address Steelville Date signed 2-17-47

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

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

RECEIVED

District Health Officer No. 4
District File Number 347-32
Date Filed 3-4-47

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.....

C. Jesse Gahr

Registered Apprentice No. 133

working under my personal supervision.

Signed *Thomas S. Galbreath*

Licensed Embalmer No. 4332

P. O. Address *Steelville, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County Iron
(b) City or town East End
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Sarah Scott Short

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

4. Sex F 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 _____ years

7. Birth date of deceased Oct. 14, 1898
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ (Less than one day)
hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

{ 14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 _____ Year 47 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 _____

Due to _____

Due to _____

Other conditions _____ (include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

Duration
Cancer womb.
48B
PHYSICIAN
Underline the cause to which death should be charged statistically.

S-4695