SEP 30 1927

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

Do not use this space.

25215

File No. ____

Registered No. 146

1. PLACE OF DEATH
County: Randolph
Registration District No.: 735
Township: ____
Primary Registration District No.: 3034
City: Moberly (No. 515 Logan Terrace St. 3rd Ward)

2. FULL NAME: Catherine Short
(a) Residence. No. 515 Logan Terrace 3rd 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. ____ ds. How long in U.S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR): No data

7. AGE: Years 67 | Months Unknown | Days | If LESS than 1 day, ____ hrs. or ____ min.

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

9. BIRTHPLACE (CITY OR TOWN) ____
(STATE OR COUNTRY) Ireland

PARENTS

10. NAME OF FATHER: Edward Short
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ____
(STATE OR COUNTRY) Ireland
12. MAIDEN NAME OF MOTHER: Anna Walsh
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ____
(STATE OR COUNTRY) Ireland

14. INFORMANT: Miss Anna Short
(Address) Moberly Mo

15. FILED 8/17, 1927 Thos. J. Fleming, REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Aug 13th 1927

17. I HEREBY CERTIFY, That I attended deceased from May, 1927, to Aug 13, 1927, 19____ that I last saw her alive on Aug 13, 1927, 19____, and that death occurred, on the date stated above, at 10:05 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia
(duration) ____ yrs. 2 mos. ____ ds.
CONTRIBUTORY (SECONDARY) Fracture of Femur
(duration) ____ yrs. 3 mos. ____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? ____
DID AN OPERATION PRECEDE DEATH? No. DATE OF ____
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) L. T. Hagan, M. D
8-17th, 1927 (Address) Moberly 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: Moberly Mo
DATE OF BURIAL: 8-17th 1927

20. UNDERTAKER: Moran and Son
ADDRESS: Moberly Mo

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Randolph — Registration District No. 735 — File No.
Township — Primary Registration District No. 3034 — Registered No. 46
City Moberly (No. ..... St. ..... Ward)

2. FULL NAME Catherine 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	W	S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED 10-12, 1927 Thos. S. Fleming
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 13 1927

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ....., 19..... that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia
Fracture caused by accidental fall from a chair. (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Fracture of femur
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) S. P. Ragan, M. D
, 19 (Address) Moberly 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	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

RECEIVE A[illegible]E FOR CERTIFICATES U[illegible]L [illegible]AW

S-25215