

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **Bellevue** (No. **City Hospital**)

File No. **38532**

Registered No. **11211**

2. FULL NAME

(a) Residence. No. **5960** **Bellevue** St. **15** Ward. (If nonresident give city or town and State)

Length of residence in city or town where death occurred **10** yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** **4. COLOR OR RACE** **white** **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** **widow** (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **April 12 1885**

7. AGE YEARS **70** MONTHS **8** DAYS **3** IF LESS THAN 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **Laborer**
(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) **Indiana**

10. NAME OF FATHER **John Short**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

12. MAIDEN NAME OF MOTHER **Elizabeth Unknown**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

14. INFORMANT (Address) **Edmund R. Sheridan** **City Hospital**

15. FILED **DEC 15 1927** **Max B. Starckoff** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Dec 15 1927**

17. I HEREBY CERTIFY, That I attended deceased from **Dec 12 1927** to **Dec 15 1927** that I last saw him alive on **Dec 15 1927** and that death occurred, on the date stated above, at **City Hospital**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar pneumonia
108
931 **10/10/27**
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **Chronic myocarditis**
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? DATE OF.....
WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) **Edmund R. Sheridan** M. D.
12/15/27 (Address) **City Hospital**

*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 **Indianola Iowa** **DATE OF BURIAL** **13-16 1927**

20. UNDERTAKER **West Bros 2207 So Grand** **ADDRESS**

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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.

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