

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

Do not use this space.

4787

1. PLACE OF DEATH

County Harrison
Township Chapel
City _____ (No. _____)

Registration District No. 383
Primary Registration District No. 5534

File No. _____
Registered No. 4
St. _____ Ward _____

2. FULL NAME

Francis Newton 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 M 4. COLOR OR RACE W 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)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
11

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) Chapel Hill mo
(STATE OR COUNTRY)

10. NAME OF FATHER F N Short

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Wm Vasey mo
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Leann Cowan

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Wm Vasey mo
(STATE OR COUNTRY)

14. INFORMANT F N Short
(Address) Wm Vasey mo

15. FILED 2-10-30 W J Lane
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-8-30

17. I HEREBY CERTIFY, That I attended deceased from Feb-8- 1930 to Feb-8- 1930 that I last saw h. _____ alive on _____, and that death occurred, on the date stated above, at 9 a-m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia
10/18 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.

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

8 DID AN OPERATION PRECEDE DEATH? DATE OF _____

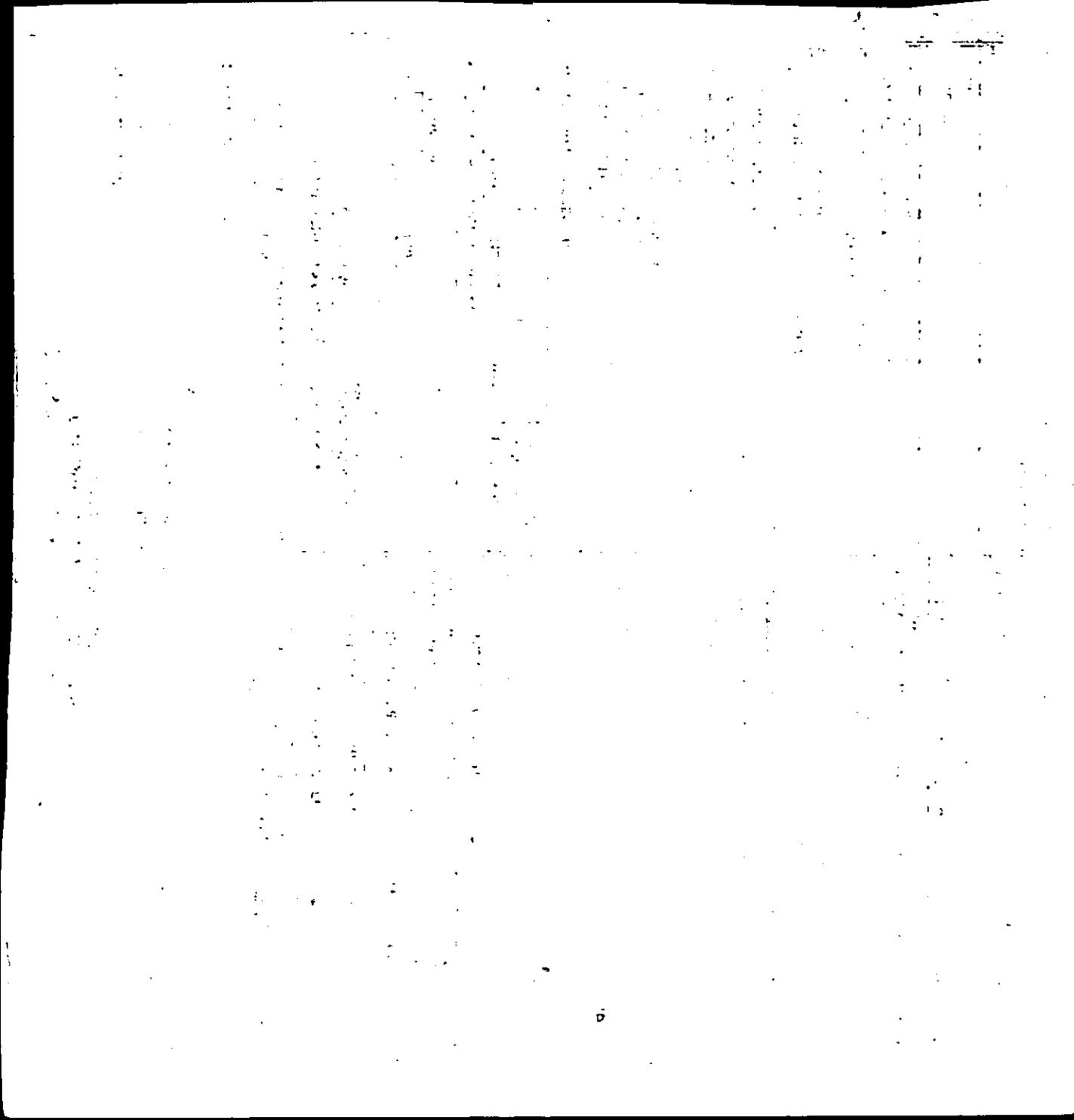
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS physical
(Signed) J E Ferrell M.D.
, 19 _____ (Address) Wm Vasey 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 Wm Vasey mo DATE OF BURIAL 2-9-30

20. UNDERTAKER _____ ADDRESS _____



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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
 County Howell Registration District No. 383 File No.
 Township Chapel Primary Registration District No. 3-1-34 Registered No. 4
 City (No.) St. Ward

2. FULL NAME Frankie Newton 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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.
11

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)

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) G. J. Gove
 15. FILE NO. 210 30 1930 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-8-30

17. I HEREBY CERTIFY, That I attended deceased from 1930,
 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
Bronchial
 CONTRIBUTORY (SECONDARY)
 (duration) yrs. mos. da.

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)..... M. D.
 , 19 (Address) 100

*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
 ADDRESS 19

20. UNDERTAKER Gno J. Duquenois ADDRESS Mt. View Mo

SUPPLEMENTARY

I NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

L8LH - S