

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

8106

**1. PLACE OF DEATH**

County.....  
Township.....  
City.....

Registration District No. **791**  
Primary Registration District No. **1003**  
City Hospital # **2**

File No.....  
Registered No. **2479**  
St..... Ward)

**2. FULL NAME**

**WILLIE JAMES SHORT**  
(a) Residence. No. **322 S. JEFFERSON**, **21** Ward. (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred **8** yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX **H** 4. COLOR OR RACE **@** 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) **12-25-1905**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
**25 1 26**

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work **HOUSE WORK**  
(b) General nature of industry, business, or establishment in which employed (or employer) **244**  
(c) Name of employer

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

10. NAME OF FATHER **HIGH SHORT**  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) **MISS**  
(STATE OR COUNTRY)  
12. MAIDEN NAME OF MOTHER **SALLIE AMA**  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **MISS**  
(STATE OR COUNTRY)

14. INFORMANT **A. GERTRUDE CREAN**  
(Address) **CITY HOSPITAL #2**

15. FILED **21 1931**  
MAY 21 1931  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **2-21-1931**  
17. I HEREBY CERTIFY, That I attended deceased from **1-13-1931**, to **2-21-1931**, that I last saw h.c. alive on **2-21-1931**, and that death occurred, on the date stated above, at **2:35 P. m.**

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

**BILAT. BRONCHO-PNEUMONIA**  
**IIA (NON-TUBERCULAR)**  
**107A** (duration) yrs. mos. **3** ds.  
CONTRIBUTORY **INFLUENZA**  
(SECONDARY) (duration) yrs. **1** mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
IS NOT AT PLACE OF DEATH **AT HOME**  
DID AN OPERATION PRECEDE DEATH? **NO** DATE OF **(1)**  
WAS THERE AN AUTOBPSY? **YES**  
WHAT TEST CONFIRMED DIAGNOSIS? **SMOKOFF - CLINICAL - LAB**  
(Signed) **Henry H. Hampton, M. D.**  
**2-23-1931** (Address) **City Hospital #2**

\*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 **Columbus Miss** DATE OF BURIAL **2-28-1931**  
20. UNDERTAKER **W. S. Madson Co** ADDRESS **4202**

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.

