

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

Do not use this space.

19741

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1008**
 City..... (No. **5** State **City Hospital #1** St. Ward)

File No.
 Registered No. **5730**

2. FULL NAME

Margie Short
 (a) Residence. No. **1737** **2579 State St.** St. **22** 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) June 19, 1928

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
 7 10 29

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. **None**
 (b) General nature of industry, business, or establishment in which employed (or employer).
 (c) Name of employer.

9. BIRTHPLACE (CITY OR TOWN) **St. Louis 1.**
 (STATE OR COUNTRY) **Missouri**

10. NAME OF FATHER Ernest Short

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Kentucky 2**
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Pauline Holmes
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Ohio**
 (STATE OR COUNTRY)

14. INFORMANT Ernest Short
 (Address) **2579 State St.**

15. FILED 19 1974
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **May 18, 19 31**

17. No Physician in attendance
 I HEREBY CERTIFY, That I attended deceased from

..... 19....., to..... 19....., and that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at **10:30 A.** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Simple Meningitis
Caused Unknown
 (duration) yrs..... mos..... ds.

CONTRIBUTORY (SECONDARY) **790**
 (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? **Yes**

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) **John J. [Signature]** M.D.
5/19, 19 31 (Address) **City, Missouri**

*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 **St. Matthews**

DATE OF BURIAL **5/20 19 31**

20. UNDERTAKER **John P. Collins & Co**

ADDRESS **928 W. Grand**

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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