

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

Do not use this space.

33112

OCT 14 1937

1. PLACE OF-DEATH

County.....
Township.....
City...St. Louis, Mo. (No. Bethesda Hospital)

Registration District No. 791
Primary Registration District No. 1003

File No.....
Registered No. 9166
St. Ward)

2. FULL NAME Infant Short

(a) Residence, No. Bethesda Hospital 1st. Ward. NR
(Usual place of abode) Bethesda Hospital (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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Infant

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-19-1937

7. AGE YEARS MONTHS DAYS If LESS than 1 day, 3 hrs. or 3 min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) St. Louis Mo
(STATE OR COUNTRY)

13. NAME Unknown

14. BIRTHPLACE (CITY OR TOWN) Unknown
(STATE OR COUNTRY)

15. MAIDEN NAME Juanita Short

16. BIRTHPLACE (CITY OR TOWN) Marissa
(STATE OR COUNTRY) Illinois

17. INFORMANT Mother Juanita Short
(ADDRESS) Marissa

18. BURIAL, CREMATION, OR REMOVAL PLACE City Cemetery 9/30/37

19. UNDERTAKER Joseph H. Loman
(ADDRESS) City

20. FILED SEP 20 1937 St. Louis
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-20-1937

22. I HEREBY CERTIFY, That I attended deceased from 19....., to 19.....

I last saw h. alive on 19..... Death is said to have occurred on the date stated above, at 1400 m.

The principal cause of death and related causes of importance were as follows:

Prematurity Date of onset

Other contributory causes of importance:

Respiratory failure

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?

Also, specify

(Signed) Joseph H. Loman M. D.

(Address) Bethesda Hill Hospital

