

MAY 15 1940

State File No. \_\_\_\_\_

Registration District No. 875

Primary Registration District No. 3039

Registrar's No. 122

I. PLACE OF DEATH:

(a) County Vernon  
 (b) City or town Nevada  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Nevada Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 4 days  
(Specify whether years, months or days)  
 In this community 4 years

8. (a) PRINT FULL NAME Ethel Mae Short - 1030

8. (b) If veteran, name war no 8. (c) Social Security No. no

4. Sex Female 5. Color or race W. 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife J. W. Short 6. (c) Age of husband or wife if alive 32 years

7. Birth date of deceased Sept. 2, 1900 1899  
(Month) (Day) (Year)

8. AGE: Years 40 Months 7 Days 23  
If less than one day hr. min.

9. Birthplace Wahine Co. Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business \_\_\_\_\_

12. Name U. S. Neff

13. Birthplace Little Rock Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Julia Ann Blitzer

15. Birthplace Wahine Co. Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant J. W. Short

(b) Address 1107 N. Commercial Nevada Mo.

17. (a) Burial (b) Date thereof 4/28/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Newton Burial Park

18. (a) Signature of funeral director Martha Cechinger

(b) Address Nevada Mo.

19. (a) 4-26-1940 (b) Green O. Bays  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Vernon  
 (c) City or town Nevada Mo.  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 1107 N. Commercial  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A. 40 yrs. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 25  
 year 1940 hour 3 minute 45 P.M.

21. I hereby certify that I attended the deceased from April 30  
1940, to April 25, 1940  
 that I last saw her alive on April 25, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death Toxic myocarditis Duration 3 days

Due to Pelvic peritonitis 1 week

Due to Pelvic cellulitis ?

Other conditions (Include pregnancy within 3 months of death) None

Major findings: Of operations none

Of autopsy none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)   
 (b) Date of occurrence   
 (c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

795 While at work?  (Specify type of place)  
 (a) Means of injury

23. Signature J. W. Cresswell (M. D. or other) M.D.  
 Address Nevada Mo. Date signed 4/26/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

RECEIVED

District Health Officer No. 7,

District File Number 5-40-240

Issue Date Filed 5-6-42

5014 7-11

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Mark Eisinger  
Licensed Embalmer No. 3656  
P. O. Address Nevada Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 16362

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
 (a) County Vernon Nevada  
 (b) City or town \_\_\_\_\_  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: \_\_\_\_\_  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
 In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Ethel Mae Shurl  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year \_\_\_\_\_

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
40 7 22 \_\_\_\_\_ h. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_ (City, town, or county) (State or foreign country)

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
 (Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
 (c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

20. DATE OF DEATH Month Apr. day 25 - 40  
 year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_;  
 that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Toxic Myocarditis

Due to Pelvic peritonitis 1 wk

Due to Pelvic cellulitis

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: in general

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

93C

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

(Specify type of place)  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration  
2 hrs  
1 wk  
 PHYSICIAN  
 \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD  
 ROWENA MOORE

SUPPLEMENTARY

