

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

29839

State File No. _____

Registration District No. 824 Primary Registration District No. 7 Registrar's No. _____

1. PLACE OF DEATH:
(a) County Shannon
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Rural
(If not in hospital or institution, write street number or location) 2
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (years, months or days)

3. (a) PRINT FULL NAME: Mary Sue Short 67A
3. (b) If veteran, name war X **3. (c) Social Security** No. X

4. Sex: F **5. Color or race:** A **6. (a) Single, widowed, married, divorced:** Single
6. (b) Name of husband or wife: _____ **6. (c) Age of husband or wife if alive:** _____ years
7. Birth date of deceased: Oct 42 1932
(Month) (Day) (Year)

8. AGE: Years 7 Months 10 Days 15 If less than one day _____ hr. _____ min.

9. Birthplace: Burch Grove (City, town, or county) MA (State or foreign country)

10. Usual occupation: _____

11. Industry or business: _____
12. Name: Halter Short
13. Birthplace: MO (City, town, or county) (State or foreign country)
14. Maiden name: Alta Keeling
15. Birthplace: MO (City, town, or county) (State or foreign country)

16. (a) Informant: Richard Keeling
(b) Address: Bunker MO

17. (a) (Burial, cremation, or removal): Rural **(b) Date thereof:** 8-25-40
(Month) (Day) (Year)
(c) Place: burial or cremation: Heaton's Church

18. (a) Signature of funeral director: none 7/11/40
(b) Address: _____

19. (a) (Date received local registrar): 8-27-40 **(b) (Registrar's signature):** Frank Hyde MA

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Shannon
(c) City or town Rural (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 27 day Aug
year 1940 hour 4 minute 0 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: Pneumonia

Due to: _____
Due to: _____

Other conditions: (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy: _____

Duration
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? _____

While at work? _____ (Specify type of place) **(e) Means of injury:** _____

23. Signature: Frank Hyde (M. D. or other) 1
Address: _____ MO **Date signed:** 8-25-40

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

RECEIVED

District Health Officer No. 5,

District File Number 940958

Date Filed _____

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

29 839

State File No. _____

Registration District No. 824

Primary Registration District No. _____

Registrar's No. _____

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

1. PLACE OF DEATH

(a) County Shannon

(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Rural Moore Inf.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Mary Sue Short

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex _____

5. Color or race _____

6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____
If less than one year

hr _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 8-30-40 (b) Frank Hyde M.D.
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 27
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: pneumonia bronch.
no complications

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

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?

While at work? _____
(Specify type of place) (c) Means of injury.

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

REGISTERED POLICE ACADEMY TO BE HELD AT
HYABO TO STANDARD GRADUATE

S-29839