

17-50  
X23159

NOV 15 1940  
Registration District No. 04

Primary Registration District No. 3008

Registrar's No. 274

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

1. PLACE OF DEATH: Galloway  
 (a) County Fullon  
 (b) City or town Fullon  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: State Hospital no 1 days  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 27 days  
 (Specify whether In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME John Wesley Short  
 3. (b) If veteran, name war DK  
 3. (c) Social Security No. DK

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced widowed  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased July 1858  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>52</u>	<u>3</u>	<u>13</u>	<u>—</u> hr. <u>—</u> min.

9. Birthplace mo 0  
 (City, town, or county) (State or foreign country)  
 10. Usual occupation Plasterer 9

11. Industry or business \_\_\_\_\_  
 12. Name Newton Short 9  
 13. Birthplace DK 1  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Susan 1  
 15. Birthplace DK  
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Paul Cross  
 (b) Address Joplin 2609 E. 54

17. (a) Removal (b) Date thereof Oct 23, 1940  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Nevada, Mo.

18. (a) Signature of funeral director Fred Thomas  
 (b) Address Nevada Mo

19. (a) Oct 23, 1940 (b) P. M. Cross  
 (Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Oct. day 22  
 year 1940 hour 6 minute 25 P.M.  
 21. I hereby certify that I attended the deceased from Sept  
25, 1940, to Oct. 22, 1940  
 that I last saw him alive on Oct 22, 1940,  
 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of left maxillary ethmoid sphenoid  
of frontal sinus ✓

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions lobular pneumonia (right) 2 days  
 (Include pregnancy within 3 months of death)

PHYSICIAN  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy as above  
 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 Fred Thomas (M. D. or other) 1  
 Address Fullon mo Date signed 11/2 40

108  
5

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**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 RB Army

Licensed Embalmer No. 1760

P. O. Address Merida no

**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, fact should be so stated above.**

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

No. 2B  
2-21-40  
1 X2/25

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 34953  
Registrar's No. \_\_\_\_\_

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 104

Primary Registration District No. 3008

1. PLACE OF DEATH:

(a) County Calloway  
(b) City or town Fulton  
(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

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.

3. (a) PRINT FULL NAME John Wesley Short

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid

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 52 Months 3 Days 13 If less than one day \_\_\_\_\_ 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. (Month) (Day) (Year)

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

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

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

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH. Month Oct day 22 year 1940 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 Carcinoma of left maxillary Ethmoid Sphenoid & frontal sinuses  
Due to primary and metastatic focal pneumonia  
Due to \_\_\_\_\_

Other conditions. (Include pregnancy within 3 months of death) 53

Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_

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 Jarrell Thomas (M. D. or other) \_\_\_\_\_

Address Fulton, Mo Date signed \_\_\_\_\_

SUPPLEMENTARY

