

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **43010**
Registrar's No. **65**

JAN 17 1941
Registration District No. **460**

Primary Registration District No. **427A**

1. PLACE OF DEATH:
(a) County **Lafayette**
(b) City or town **Higginsville,**
(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. (Specify whether
years, months or days) **2**

3. (c) PRINT FULL NAME **Helen May Short**
3. (b) If veteran, name war. 3. (c) Social Security No.
4. Sex **Female** 5. Color or race **White** 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. **8 Dec 1940**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
2 hr. min.
9. Birthplace. **Higginsville, Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation. **D**
11. Industry or business. **I**

MOTHER FATHER
12. Name **Fay Short**
13. Birthplace **Kansas City, Kansas**
(City, town, or county) (State or foreign country)
14. Maiden name **Pearl Clawson**
15. Birthplace **Peabody, Colo**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature. **May C Short**
(b) Address **Higginsville, Mo.**
17. (a) **Burial** (b) Date thereof. **Dec 11 1940**
(Burial, cremation, or removal). (Month) (Day) (Year)
(c) Place: burial or cremation **Higginsville**

18. (a) Signature of funeral director. **Ad... 1/13**
(b) Address **Higginsville, Mo.**
19. (a) **1-8-1941** (b) **F... 1/13**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Lafayette**
(c) City or town **Higginsville Mo**
(If outside city or town limits, write "RURAL")
(d) Street No. **0** (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Dec** day **10**
year **1940** hour minute M.
21. I hereby certify that I attended the deceased from **Dec 8-1940**
to **Dec 10 1940**
that I last saw her alive on **Dec 10 - 1940**
and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchopneumonia**
Due to **Inspiration of Meconium into Lungs at Birth.**
Due to **16 D 10**
Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: Of operations **—**
Of autopsy **none**
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) **no**
(b) Date of occurrence **none**
(c) Where did injury occur? **none** (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 **MD**
23. Signature **E... MD** (M. D. or other)
Address **Higginsville Mo** Date signed **1-8-41**

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

MARGIN RESERVED FOR BINDING

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.

Rev. 5-17-39
50M-5-17-39
U. S. G. P. 1 X1931

Date Filed 1-10-41
Number of Number
Health Officer No. 8

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..... *W.H. Stode*
Licensed Embalmer No.....
P.O. Address..... *Higginsville, Md*

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.