

S. No. 2
M-5-43
5-17-39
I X35677

14296

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAY 13 1947

Registration District No. 224

Primary Registration District No. 5801

Registrar's No. 25

1. PLACE OF DEATH:

(a) County Monroe

(b) City or town Rural Washington
(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 4 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Monroe

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME TEDFORD BARKLEY SHORT

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION 2nd

20. DATE OF DEATH: Month May day 3rd
year 1947 hour 5 minute 0:4 M.

21. I hereby certify that I attended the deceased from Feb 2
2, 1947, to May 2, 1947
that I last saw h. im alive on April 30, 1947
and that death occurred on the date and hour stated above.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Bessie Short

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

7. Birth date of deceased July 25 1873
(Month) (Day) (Year)

Immediate cause of death Cerebral hemorrhage Duration 5 days

8. AGE: Years Months Days If less than one day

73 9 6 hr. _____ min.

Due to _____

Due to _____

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

Other conditions Arterio sclerosis (general)
(Include pregnancy within 3 months of death)

10. Usual occupation Farmer

11. Industry or business Retired Farmer

Major findings: 83A

Of operations _____

Of autopsy _____

PHYSICIAN Underline the cause to which death should be charged statistically.

MOTHER FATHER { 12. Name Robert R. Short

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

14. Maiden name Marion Lee

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

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? _____

16. (a) Informant Mrs W. H. Howell

(b) Address Humwell Mo

17. (a) Burial (b) Date thereof 5/4/1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation J. C. P. Care Humwell

While at work? _____ (Specify type of place)

(e) Means of injury 0

18. (a) Signature of funeral director Mrs. Seta Givan

(b) Address Humwell Mo

23. Signature R. H. Parker (M. D. cancel)

Address Humwell Mo Date signed 5-3-47

19. (a) May 10 1947 (b) Chie Lee
(Date received local registrar) (Registrar's signature) #12-1

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
DEPARTMENT OF HEALTH
STATE BOARD OF HEALTH
25-47-821
MAY 12 1947

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.....

Paul E. Hayes....., Registered Apprentice No. *417*,
working under my personal supervision.

Signed..... *E Hayes*.....

Licensed Embalmer No. *1437*.....

P. O. Address..... *Chubina 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, fact should be so stated above.