

FILED JUN 24 1947

State File No. ....

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 442A

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Springfield  
(c) Name of hospital or institution: St. John's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7 da  
In this community seven days  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Lawrence  
(c) City or town Mt. Vernon  
(If outside city or town limits, write "RURAL")  
(d) Street No. ....  
(If rural, give location)  
(e) Citizen of foreign country? .....

3. (a) PRINT FULL NAME

Joseph F Short

3. (b) If veteran, name war None 3. (c) Social Security No. none

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

6. (b) Name of husband or wife Mary 6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased Aug. 12, 1879  
(Month) (Day) (Year)

8. AGE: Years 73 Months 9 Days 13 If less than one day hr. min.

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

10. Usual occupation Farming

11. Industry or business Farming

12. Name John Short

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

14. Maiden name Sally Long

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

16. (a) Informant O. W Short

(b) Address Mt Vernon Mo

17. (a) Oak Grove (b) Date thereof May 30 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove

18. (a) Signature of funeral director Fossett, F Hon

(b) Address Mt Vernon Mo

19. (a) 5-26-47 (b) W E Haisley MD  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 26  
year 1947 hour Three minutes 27 A.M.

21. I hereby certify that I attended the deceased from 19  
May, 1947 to 26 May, 1947  
that I last saw him alive on 25 May, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death: cerebral Embolism  
Left Hemiplegia  
arteriosclerosis  
hypertension  
Due to .....

Other conditions: Diabetes  
(Include pregnancy within 9 months of death)  
Cerebral Artery PHYSICIAN

Major findings: 57  
Of operations .....

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) .....

23. Signature W E Haisley (M. D. or other)  
Address 202 E Pershing Date signed 26/5/47

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

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2  
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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.....

*By me*

....., Registered Apprentice No.....

working under my personal supervision.

Signed..... *Max H. Smith* .....

Licensed Embalmer No..... *4252* .....

P. O. Address..... *W. Keener St* .....

**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.**