WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

2 PLACE OF DEATH

County Pettis DuBoiss

Township or Village or City Sedalia (NO. ______ St.; ______ Ward)

Registration District No. 668 File No. 37064

Primary Registration District No. 3032 Registered No. 284

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Hebron Ernest Ballard

PERSONAL AND STATISTICAL PARTICULARS		
SEX: Male	COLOR OR RACE: White	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married
DATE OF BIRTH: Oct (Month) 5 (Day), 1829 (Year)		
AGE: 84 yrs. 1 mos. 21 ds.	If LESS than 1 day, ___ hrs. or ___ min.?	
OCCUPATION (a) Trade, profession, or particular kind of work: Farmer		
(b) General nature of industry, business, or establishment in which employed (or employer): General Farming		
BIRTHPLACE (City or town, State or foreign country): Ohio		
PARENTS — NAME OF FATHER: John Ballard		
BIRTHPLACE OF FATHER (City or town, State or foreign country): U. S. A.		
MAIDEN NAME OF MOTHER: Don't Know		
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Don't Know		

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mabel Ballard

(ADDRESS) 320 East Fourth St

Filed Nov 25, 1913 H. B. Perry REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov. 24 (Month) (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from June 1, 1913, to Nov 24, 1913, that I last saw him alive on Nov 24, 1913, and that death occurred, on the date stated above, at 830 P m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

97 / 165

(Duration) 25 yrs. ___ mos. ___ ds.

Contributory (Secondary) Senility

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) R. R. Barnum M. D.

8 11/25, 1913 (Address) Sedalia Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? ______

Former or usual residence ______

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Crown Hill	Nov 26, 1913
UNDERTAKER: McLaughlin Bros	ADDRESS: Sedalia

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

PLACE OF DEATH

County_____

Township_____ *or*

Village_____ *or*

City_____ (NO._____, _____ St.; _____ War

MISSOURI STATE BO/
BUREAU OF VITAL
CERTIFICATE OF

Registration District No._____ File No.____

Primary Registration District No._____ Registered N

FULL NAME_____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

_____, *1*_____
(Month) (Day) (Year)

AGE

_____yrs._____mos._____ds.

If LESS than 1 day, ___hrs. or ___min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)_____

(ADDRESS)_____

Filed _____, 191___, _____
REGISTRAR

MEDICAL CERTIFICATE C

DATE OF DEATH

_____
(Month)

I HEREBY CERTIFY, that

_____, 191___, to___

that I last saw h_____ alive on_____

and that death occurred, on the date

The CAUSE OF DEATH* was as fol

_____

_____

_____

_____(Duration)_____

Contributory_____
(SECONDARY)

_____(Duration)_____

(Signed)_____

_____, 191___ (Address)_____

*State the Disease Causing Death, or, in (1) Means of Injury; and (2) whether Accidental,

LENGTH OF RESIDENCE (FOR HOSPITALS RECENT RESIDENTS)

At place of death____yrs.____mos.____ds. In t Stat

Where was disease contracted if not at place of death? _____

Former or usual residence_____

PLACE OF BURIAL OR REMOVAL

_____

UNDERTAKER

use of "Tumor" for malignant neoplasms); *Measles;*