

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

County Pleasant
Township Liberty
or
Village Richfield
or
City _____

Registration District No. 712

File No. 29899

Primary Registration District No. 4427

Registered No

FULL NAME

(NO. _____ St. _____ Ward _____)
Clara Minnie Myrtle Custer Ballard

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

PERSONAL AND STATISTICAL PARTICULARS

SEX <i>Female</i>	COLOR OR RACE <i>W</i>	SINGLE MARRIED WIDOWED OR DIVORCED (initials the word) <i>Single</i>
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DATE OF BIRTH 3 18 1909
(Month) (Day) (Year)

AGE 11 yrs. 6 mos. 6 ds. If LESS than
1 day, ____ hrs.
or ____ min.?

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

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

BIRTHPLACE
(City or town,
State or foreign country)

NAME OF FATHER John Ballard

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

MAIDEN NAME OF MOTHER *Louise C. Thorne*

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Ballard
(Address) Richmond

Filed Sept 23, 19120 Edward A. Oliver

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 9 23 1920
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 9-16, 1920, to 9-23, 1920,
that I last saw ~~her~~ alive on 9-23, 1920,
and that death occurred, on the date stated above, at 2:00 p.m.

The CAUSE OF DEATH* was as follows:

115A
36 @ beer of Tonsils
20 (Duration) _____ yrs. _____ mos. 6 ds.

Contributory: Septic infection
(SECONDARY)

(Duration) 1 yrs. 1 mos. 0 ds.

(Signed) *W. E. Hamble*

8/17/23, 19120 (Address) Richmond

*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 11 yrs. 6 mos. 6 ds. In the State 11 yrs. 6 mos. 6 ds.

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

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
1000	1000

Ware Chapel 9-24-1910

UNDERTAKER	ADDRESS
James P. L...	1234 E. 1st St.

Wm. J. Carey, New York

PLACE OF DEATH

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

County _____
 Township _____
 or _____
 Village _____
 or _____
 City _____

Registration District No. _____ File No. _____
 Primary Registration District No. _____ Registered No. _____

(NO. _____ St.: _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH		
(Month) _____ (Day) _____ (Year) _____		IF LESS than 1 day, _____ hrs. or _____ min.?
AGE		_____ yrs. _____ mos. _____ ds.

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) _____

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 OF DEATH

DATE OF DEATH

(Month) _____, 191____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(SECONDARY)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____, 191____ (Address) _____ M. D.

*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

UNDERTAKER

ADDRESS

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.