

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

15570

1. PLACE OF DEATH

County Franklin Registration District No. 1029 File No. 82
Township East Shelby Primary Registration District No. 5602 Registered No. 82
City North (No. _____ St. _____ Ward _____)

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Aug 2-1843

DATE OF BIRTH (MONTH, DAY AND YEAR)

AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
83 8 13

OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (CITY OR TOWN) Philadelphia Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER James Ballinger

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Kentucky
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Rebecca Dimirdle

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Kentucky
(STATE OR COUNTRY)

INFORMANT (Address) July 1 1927 Mattie C. Hoverton

FILED July 1 1927 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 15 1927

17. I HEREBY CERTIFY, That I attended deceased from Apr 25 1927, to May 14 1927, that I last saw him alive on May 14 1927, and that death occurred, on the date stated above at 6 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Diabetes Mellitus
57 (duration) ? yrs. mos. da.
CONTRIBUTORY (SECONDARY) Insanity (duration) ? yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No DATE OF ✓

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? ✓

(Signed) C. C. Gibson, M. D.

, 19 (Address) North 2nd

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Linville Cemetery 5-16 1927

20. UNDERTAKER J. W. Hudson ADDRESS Echlin

V. S. No. 2.

WRITE PLAINLY, WITH UNFADING INK--THIS IS 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.

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....
Township..... Primary Registration District No..... Registered No.....
City..... (No.)..... St..... Ward.....

2. FULL NAME

(a) Residence, No..... St.,..... Ward.....
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX..... 4. COLOR OR RACE..... 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND or WIFE of

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE..... YEARS..... MONTHS..... DAYS..... IF LESS than 1 day,..... hrs. or..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employee).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY)

PARENTS

14. Informant..... (Address)

15. Filed..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)..... 19.....

17. I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19....., that I last saw him..... alive on....., 19....., and death occurred, on the date stated above, at.....
THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)..... (duration)..... yrs. mos.

18. WHERE WAS DISEASE CONTRACTED..... (duration)..... yrs. mos.

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., 19..... (Address)

*State the DISEASE CAUSING DEATH, or in death from VOLUNTARY CAUSES, or (1) MANNER AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL..... DATE OF BURIAL.....

20. UNDERTAKER..... ADDRESS.....

M. 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.

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V. S. NO. 3