

JAN 28 1928

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

Do not use this space.

43934

1. PLACE OF DEATH *North Smith*  
 County.....  
 Township.....  
 City..... (No. .... St. .... Ward)  
 Registration District No. *903*  
 Primary Registration District No. *8211*  
 File No. ....  
 Registered No. *28*

2. FULL NAME *Theo May Ballenger*  
 (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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female*  
 4. COLOR OR RACE *W*  
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Infant*  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Infant*  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Dec 12 1927*  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *4 hrs.*  
 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work *Infant*  
 (b) General nature of industry, business, or establishment in which employed (or employer) *—*  
 (c) Name of employer *—*  
 9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Grant city Mo*  
 10. NAME OF FATHER *H.K. Ballenger*  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Osaka Iowa*  
 12. MAIDEN NAME OF MOTHER *Karl Stogee*  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Thurston Mo*  
 14. INFORMANT *H.K. Ballenger*  
 (Address) *Grant city*  
 15. FILED *12/28* 19 *28* *John Anderson*  
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 12 1928*  
 17. I HEREBY CERTIFY That I attended deceased from *Dec 12 1928* to *Dec 12 1928* that I last saw him alive on *Dec 11 1928*, and that death occurred, on the date stated above, at *A.M.*  
 THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*4 hours after birth*  
*Mahorholi influenza*  
 119 (duration) yrs. mos. ds.  
 150 (duration) yrs. mos. ds.  
 CONTRIBUTORY (SECONDARY) *Influenza*  
 (duration) yrs. mos. ds.  
 18. WHERE WAS DISEASE CONTRACTED *9/11/28*  
 IF NOT AT PLACE OF DEATH.....  
 DID AN OPERATION PRECEDE DEATH..... DATE OF.....  
 WAS THERE AN AUTOPSY?.....  
 WHAT TEST CONFIRMED DIAGNOSIS.....  
 (Signed) *John Anderson*, M. D.  
 (Address) *Grant City Mo*  
 \*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.  
 19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Alleendale Cem* DATE OF BURIAL *Dec 12 1928*  
 20. UNDERTAKER *Family* ADDRESS *Grant City*

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.

