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

Do not use this space.

12264

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 2003

City St. Louis (No. 4374 Washington St. ..... Ward)

File No. .....

Registered No. 2741

2. FULL NAME James Moores Ball

(a) Residence. No. 4374 Washington St. 19 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Noami Ball

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 4-1862

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
66-	5	26	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Oculist

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) West Union
(STATE OR COUNTRY) Iowa

PARENTS

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT L. Marshall Ball
(Address) 4374 Washington

15. FILED ..... 19.. [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/1 19..

17. I HEREBY CERTIFY, That I attended deceased from Feb 15, 1929, to March 1, 19.. that I last saw him alive on March 1, 1929, and that death occurred, on the date stated above, at 8:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis (Chronic) with auricular fibrillation 93C

several years (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 95A

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED 900

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) Thomas C Birdsall, M. D

, 19 (Address) 4660 Maryland Ave.

*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 Valhalla Crematory

DATE OF BURIAL March 3 1929.

20. UNDERTAKER O.R. Luxton

ADDRESS 4449 Olive St.

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.