

57
N 26 1929
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

Do not use this space.

21966

PLACE OF DEATH

County *Linn*

Registration District No. *49*

Township *Marion*

Primary Registration District No. *5652a*

City

(No.)

File No. *114*

Registered No.

St.

Ward)

2. FULL NAME

(a) Residence. No.

(Usual place of abode)

St.

Ward.

(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

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

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

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

Oct. 4th 1901

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

27

7

28

8. OCCUPATION OF DECEASED

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

Farming

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Old Marion

(STATE OR COUNTRY)

Missouri.

10. NAME OF FATHER

Henry Ball

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Old Marion

(STATE OR COUNTRY)

Missouri.

12. MAIDEN NAME OF MOTHER

Katherine Henning

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Old Marion

(STATE OR COUNTRY)

Missouri.

14.

INFORMANT

(Address)

Katherine White

Old Marion, Mo.

15.

FILED

6/3, 1929

H. Henning

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

June 1 1929

17.

I HEREBY CERTIFY, That I attended deceased from

June 1st 1929 to *June 4th 1929*

that I last saw him alive on *June 1 1929* and that death occurred, on the date stated above, at *8:30 P. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis of Lungs
23 1/2 (duration) *9* yrs. *9* mos. *—* ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH?

DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS

(Signed)

John Best M. D.

(Address) *Winfield, 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

DATE OF BURIAL

At Mary cemetery, Old Marion, Mo.

June 4-1929

20. UNDERTAKER

ADDRESS

Chambers & White, Old Marion, Mo.

