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

Do not use this space.

7534

File No. 7352
Registered No.

1. PLACE OF DEATH
County Schuyler
Township Prairie
City Queencity Mo (No. ..... St. ..... Ward)
Registration District No. 806
Primary Registration District No. 6052

2. FULL NAME Aquiller N Ballanger
(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	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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 5-1847

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	82	5	3	

8. 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

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Stephenson Co Ill

PARENTS
10. NAME OF FATHER Tracia Ballanger
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Nat Known
12. MAIDEN NAME OF MOTHER Hannah Wounder
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) PENN

14. INFORMANT Mrs A. N Ballanger
(Address) Queencity Mo

15. FILED ....., 19 ..... J V Jones REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb -8- 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1928, to Feb 8 1930, that I last saw him alive on Feb 7, 1930 and that death occurred, on the date stated above, at 11 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Brights disease and Organic heart Lesion
131
9533 (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 9013 (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH Home
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? General symptoms
(Signed) B. Wise, M. D.
, 19 (Address) Queencity 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 Queencity
DATE OF BURIAL 2/9 1930

20. UNDERTAKER Wm H West
ADDRESS Queencity Mo

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.