

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

Do not use this space.

22665

1. PLACE OF DEATH

County Howard,
Township Fayette,
City Fayette, (No.)

Registration District No. 378
Primary Registration District No. 4222

File No.
Registered No. 85-
St. Ward

2. FULL NAME Infant, Claud Ballow,

(a) Residence. No. St. Ward
(Usual place of abode)
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 <u>Female,</u>	4. COLOR OR RACE <u>White,</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>#</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>#</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>7 28- 30 1980</u>		
7. AGE <u>#</u>	YEARS <u>#</u>	MONTHS <u>3</u>
DAYS <u>hours,</u>		IF LESS than 1 day, <u> </u> hrs. or <u> </u> min.
8. OCCUPATION OF DECEASED <u>#</u> (a) Trade, profession, or particular kind of work (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) Missouri.

PARENTS	10. NAME OF FATHER <u>Claud Ballow,</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Missouri.</u> (STATE OR COUNTRY)
	12. MAIDEN NAME OF MOTHER <u>Elsie Williams.</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Missouri.</u> (STATE OR COUNTRY)

14. Claud Ballow,
INFORMANT
(Address) Fayette, Mo.

15. FILED 7/30, 1930 V. C. Bonham
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/28 1930
17. I HEREBY CERTIFY, That I attended deceased from 7-28 1930, to 7-28 1930
(that I last saw him alive on 7-28 1930, and that death occurred, on the date stated above, at 4:00 P. m.)

THE CAUSE OF DEATH WAS AS FOLLOWS:

Birth asphyxiation with cerebral anoxia

161B
161D (duration) 1 yrs. 1 mos. 1 ds.
CONTRIBUTORY (SECONDARY) 161B
(duration) 1 yrs. 1 mos. 1 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH no

0 DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Long labor of mother
(Signed) Wm. G. Shaw, M. D.
, 19 (Address) Fayette, 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 <u>Howard Co. 7 29 30</u>	DATE OF BURIAL <u>19 30</u>
20. UNDERTAKER <u>Gay T. Halley, Fayette, Mo.</u>	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be supplied.

