

SEP 26 1930

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

Do not use this space.

23739

1. PLACE OF DEATH

County Wagon
Township Jefferson
City Jay (No. _____)

Registration District No. 643
Primary Registration District No. 5852

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Fredelia May Ballmann
(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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Wife</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR)		
7. AGE	YEARS <u>46</u>	MONTHS <u>6</u>
	DAYS <u>11</u>	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>House wife</u> (b) General nature of industry, business, or establishment in which employed (or employer). <u>House work.</u> (c) Name of employer		
9. BIRTHPLACE (CITY OR TOWN) <u>Belle</u> (STATE OR COUNTRY) <u>Missouri</u>		
PARENTS	10. NAME OF FATHER <u>Asahel Young</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>New Orleans</u> (STATE OR COUNTRY) <u>Louisiana</u>	
	12. MAIDEN NAME OF MOTHER <u>Abelala E. Carter</u>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____	
14. INFORMANT (Address) <u>Geo. Ballmann</u> <u>Belle Mo</u>	15. <u>Sept 10, 1930</u> <u>Mrs. Lura Johnson</u> REGISTRAR	

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 20th 1930

17. I HEREBY CERTIFY, That I attended deceased from June 7th 1930 to July 20th 1930 that I last saw her alive on June 11th 1930, and that death occurred, on the date stated above, at 12:20 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer of the Liver.
4-6 E (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

4-4 E (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

at Place of death.

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? History of symptoms.

(Signed) Dr. R. J. Farrell M. D.
19 _____ (Address) Belle 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

College Hill Cemetery 7-22-1930

20. UNDERTAKER

ADDRESS

W. G. Licklider Belle 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.

WHILE FLEETING WITH CRIMINAL INTENT THIS IS A PERMANENT RECORD

