

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

Do not use this space.

41692

**PLACE OF DEATH**

County Schuyler  
Township Prarie  
City Queensity Mo, (No. .... St. .... Ward)

Registration District No. 806  
Primary Registration District No. 4485

File No. ....  
Registered No. ....

**2. FULL NAME Lucinda 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 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 28th 1852

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
78 1 25

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. Care of House  
(b) General nature of industry, business, or establishment in which employed (or employer).....  
(c) Name of employer Self

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Abraham Dykes

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Not known

12. MAIDEN NAME OF MOTHER Betsie Hicks

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Not known

14. INFORMANT NAME Mary Sommers

(Address) Lancaster Mo,

15. FILED ..... 19..... REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-23 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 19 1930 to Dec 28 1930 that I last saw her alive on Dec 22 1930 and that death occurred, on the date stated above, at 12.30 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Paralysis  
1 1/2 H  
82 D

(duration) ..... yrs. .... mos. 5 ds.

**CONTRIBUTORY (SECONDARY)**

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

**18. WHERE WAS DISEASE CONTRACTED**

\* IF NOT AT PLACE OF DEATH. ....

19. DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? General symptoms  
(Signed) B. J. W. M. D.

, 19 (Address) Queensity 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

Queensity cemetery Dec 24 1930

20. UNDERTAKER ADDRESS

Wm H West Queensity

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.

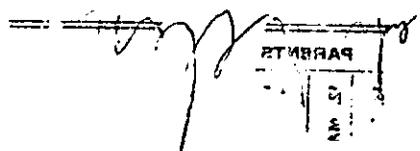
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in plain terms, so that it may be

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.  
 Count Schuyler Registration District No. 806 File No. ....  
 Township ..... Primary Registration District No. 4483- Registered No. ....  
 City Queen City (No. ....) St. .... Ward .....

2. FULL NAME Lucinda 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) widow

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .... hrs. or .... min.

8. OCCUPATION OF DECEASED  
 (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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/23 1920

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19....., that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Paralysis of Central Nerve Body

CONTRIBUTORY (SECONDARY) 820 (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)....., M. D.  
 , 19 (Address)

\*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.

14. INFORMANT (Address)

15. FILED ..... 19..... REGISTRAR J. J. Jones

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL 19.....

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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