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

V. S. No. 2.

15237

PLACE OF DEATH

County Pike   Registration District No. 684   File No. 18

Township Culver   Primary Registration District No. 5917   Registered No. 18

City .... (No. .... St. .... Ward)

FULL NAME Fred Ball — Fred Ball

(a) Residence. No. .... St., ... Ward. .... (If nonresident give city or town and State)
(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 Male | 4. COLOR OR RACE Col | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Married

DATE OF BIRTH (MONTH, DAY AND YEAR) 1850

AGE 81 | YEARS | MONTHS | DAYS | If LESS than 1 day, ... hrs. or ...... min.

OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (CITY OR TOWN) Farmer Mo
(STATE OR COUNTRY)

10. NAME OF FATHER J.M. Ball

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

12. MAIDEN NAME OF MOTHER Hannah Moore

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

INFORMANT Mrs Fred Ball
(Address) Edgewood Mo

FILED 5/10, 1931 [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-26-1931

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:
No Physician on case died after 3 mos illness following the Flu Military Tuberculosis
Dont Know (duration) ... yrs. ... 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? No. There was no physician and no coroner in this county
WHAT TEST CONFIRMED DIAGNOSIS? No justice of Peace available
(Signed) J. H. McLean, M. D
, 19 (Address) Bowling Green 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Knob Cemetery | DATE OF BURIAL 4/27 1931

20. UNDERTAKER [illegible] Basham | ADDRESS Eolia 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No..... , ... St. ..... Ward

2. FULL NAME .....

(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. d

PERSONAL AND STATISTICAL PARTICULARS

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

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)

PARENTS

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)

14.
INFORMANT .....
(Address)

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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I HEREBY CERTIFY, That I attended deceased from .....
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death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

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

CONTRIBUTORY.....
(SECONDARY)

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

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

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, sta
(1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL,
HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS