

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

Do not use this space.

34979

**1. PLACE OF DEATH**

County Missouri

Registration District No. 5-31

Township Russell

Primary Registration District No. 5-718

City \_\_\_\_\_ (No. \_\_\_\_\_)

File No. \_\_\_\_\_

Registered No. \_\_\_\_\_

St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Florence M. Ball

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 6, 1865

7. AGE YEARS 65 MONTHS 9 DAYS 25 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Retired Housekeeper

(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

10. NAME OF FATHER Samuel Scott

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

12. MAIDEN NAME OF MOTHER Elizabeth Wimmer

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

14. INFORMANT Jim Ball (Address) 2nd St. Mo

15. FILED 10/3, 1931 L. P. Shacklett REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 1st 1931

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1931, to Oct 1st, 1931, that I last saw him alive on Oct 1st, 1931, and that death occurred, on the date stated above, at 5 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Myocarditis

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_

IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? NO DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS \_\_\_\_\_

(Signed) Chas. West, M. D.

1931 (Address) New Canaan

\*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 Bell Cemetery DATE OF BURIAL Oct 3 1931

20. UNDERTAKER H. C. Young ADDRESS 2nd St. Mo

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

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.

NOV 5 1931

