

SEP 24 1934

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

Do not use this space.

1. PLACE OF DEATH

County Shelby
Township Lentner
City (No.)

Registration District No. 830
Primary Registration District No. 6095

File No. 79194-X
Registered No. 25
St. Ward

2. FULL NAME

(a) Residence (Usual place of abode) James William Ballard Ward
(Usual place of abode) Shelbina Mo. R.F.D. St. (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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 3 1869
7. AGE YEARS 64 MONTHS 9 DAYS 21 If LESS than 1 day, hrs. min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marion Co.

13. NAME David Ballard

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

15. MAIDEN NAME Mary Ellen Pepper

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marion Co.

17. INFORMANT Anna J. Ballard (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE Morris Chapel DATE May 26 1934

19. UNDERTAKER E. Hayes (ADDRESS) Shelbina Mo.

20. FILED Sept 20 1934 Mrs. R. H. Wailes Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-24-1934

22. I HEREBY CERTIFY, That I attended deceased from Sept 5 1933, to 5-20-1934
I last saw him alive on 5-20-1934 Death is said to have occurred on the date stated above, at 4 P. M.

The principal cause of death and related causes of importance were as follows:
Myeloma of Lumbar vertebra.
Ribs & Skull.
530

Other contributory causes of importance:

Name of operation Clinical Date of no

What test confirmed diagnosis? Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury , 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

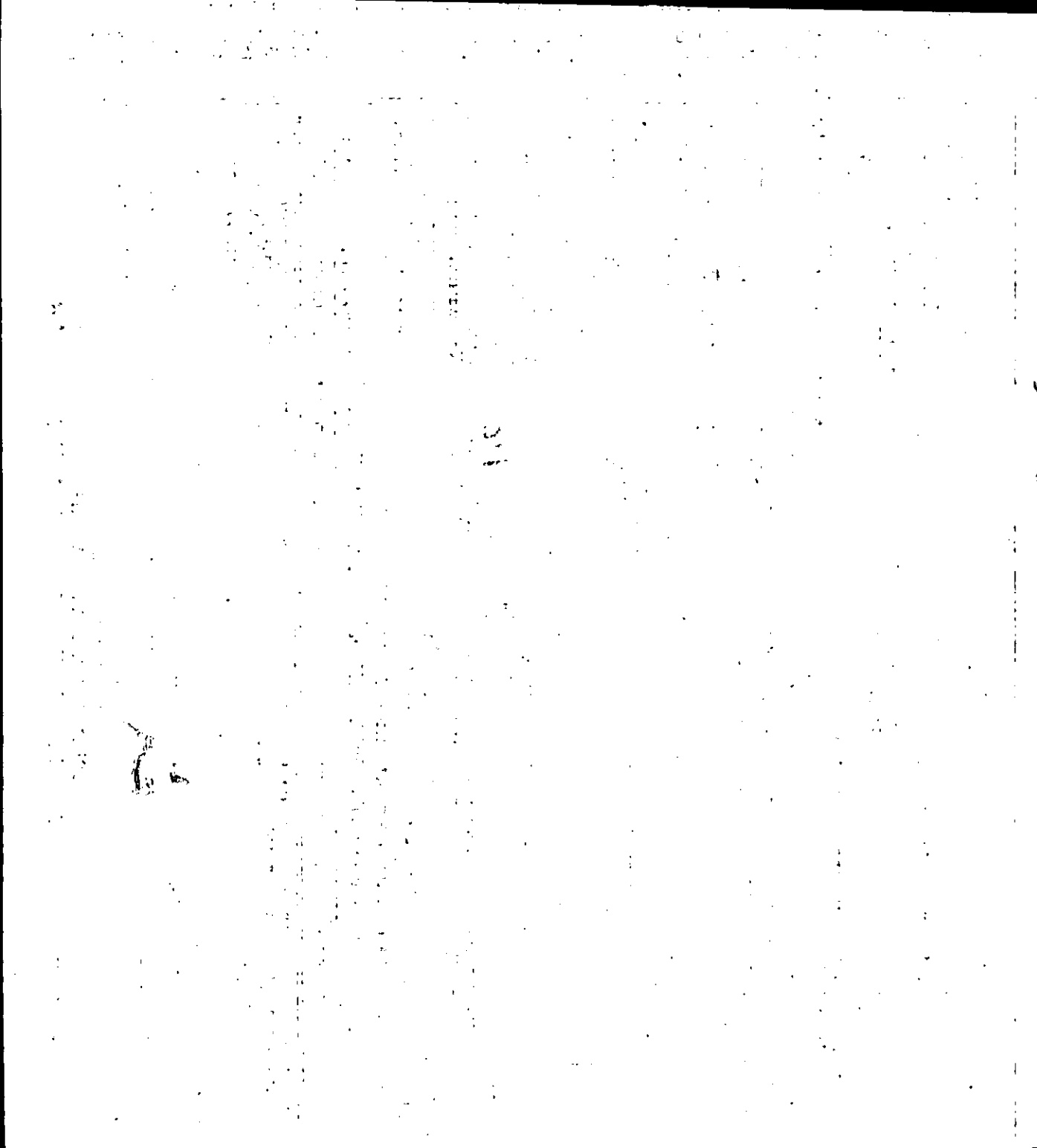
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify G. M. Wood M. D.

(Signed) Shelbina Mo.

(Address)



Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: James Wm Ballard
Who died at _____ on May 24 - 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex m Color or race w Single, married, widowed or divorced: _____

Date of birth _____ Age: Years 64 Months 9 Days 21

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month _____ Year _____
Birthplace (State or country) Rebs & Steel
Birthplace of father (State or country) _____
Birthplace of mother (State or country) Myeloma malignant
Principal cause of death: Primary Stomach Sept 15th 1934

Other contributory causes of importance _____
Name of operation Alcohol Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19 _____
Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
Name of physician Dr. A. M. Wood
Address of physician Shelburne Mo.
Signature of Registrar Mrs. R. H. Wailes Date filed _____

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

Reg. Dist. No. 830

Primary Reg. Dist. No. 6095

E. T. McGaugh
State Registrar
Special Agent.

FORWARDED TO THE CONTROLLER

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