

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

Do not use this space.

25352

AUG 9 1939

1. PLACE OF DEATH

County... *Christian*
 Township... *Key*
 City... *Key*

Registration District No. *173*
 Primary Registration District No. *4100*

File No. _____
 Registered No. *14*
 St. _____ Ward _____

2. FULL NAME *Millie Ann Ballbridge*

(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** *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED
 (OR) WIFE OF *John R. Ballbridge*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Jan 5 - 1860*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
79 6 3

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Housewife*

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) *Jacksonville Mo*

13. NAME *Benjamin Behrens*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Perry, Kansas*

15. MAIDEN NAME *Mildred Hillman*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Perry, Kansas*

17. INFORMANT (ADDRESS) *Arthur Ballbridge*

18. BURIAL, CREMATION, OR REMOVAL

PLACE *Key* DATE *July 9 1939*

19. UNDERTAKER (ADDRESS) *Key*

20. FILED *July 9 1939* *Mrs. Ray Soubree* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *July 8 1939*

22. I HEREBY CERTIFY That I attended deceased from *April 17 1939* to *July 8 1939*

I last saw her alive on *April 16 1939*. Death is said to have occurred on the date stated above, at *1 P* m.

The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage (apoplexy) Date of onset *7/6/39*

Other contributory causes of importance: *g22*

Name of operation _____ Date of _____
 What test confirmed diagnosis? *Clinical* 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? _____ (S. ecify 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 _____

(Signed) *Carl C. Heger* M. D.
 (Address) *Key*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 8/7/39