

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Northeast Hospital 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 days
(Specify whether
In this community _____
years, months or days)

NOV 14 1939

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clarion
(c) City or town Dalton (Rural)
(If outside city or town limits, write "RURAL")
(d) Street No. Rt. D. #1
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME ROBERT THOMAS BALLOWE

3. (b) If veteran, name war _____ 3. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Cora 6. (c) Age of husband or wife if alive 2 years
7. Birth date of deceased Jan 2 1869
(Month) (Day) (Year)

8. AGE: Years 70 Months 9 Days 4 If less than one day _____ hr. _____ min.

9. Birthplace Slater Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farming

MOTHER FATHER { 12. Name William Ballowe
18. Birthplace Virginia
(City, town, or county) (State or foreign country)
14. Maiden name Mary Hawk
15. Birthplace Slater Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Edgar Ballowe

(b) Address Slater Mo

17. (a) Removal (b) Date thereof 10-6-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Good Hope

18. (a) Signature of funeral director James H. Hagan

(b) Address Slater Mo

19. (a) Oct 6/39 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 6
year 1939 hour _____ minute 9 M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him/her alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumonia

Due to Interstitial cerebral hemorrhage

subdural hematoma (2)

Due to Auto-traumatism

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence 10-2-39

(c) Where did injury occur Brownsville Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, or farm, in industrial place, in public place?
on highway

(Specify type of injury) _____

23. Signature W. H. Hagan (or other)

Address K.C. Mo Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

210 m
90

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed *Wm L Ward*

Licensed Embalmer No. *3991*

P. O. Address *57 25 Virginia*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

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

Do not use this space.

1. PLACE OF BIRTH

County Jackson
Township K. C.
City K. C.

Registration District No. 399
Primary Registration District No. 1002 -
(No. Northeast Hosp -)

File No. 34881
Registered No. 3856
St. _____ Ward _____

2. FULL NAME

Robert J. Ballowe

(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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m-

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.
70 9 4

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
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) _____ (Total time years spent in this occupation)

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

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19____

19. UNDERTAKER (ADDRESS)

20. FILED 10/6 1939 M. M. Crowe
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 6 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said

to have occurred on the date stated above, at _____ m.

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

Broncho Pneumonia Date of onset _____

Int. Cerebral Hemorrhage

Other contributor causes of importance: Auto traumatism

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Accid Date of injury 10-2 1939

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

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

Manner of injury Car went off road. Not a

Nature of injury collision

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify Victor B. Buhler, M. D.

(Signed) K. C. mo.
(Address) _____

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.

TEMPORARY

