

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

**36825**  
Do not use this space.

**1. PLACE OF DEATH**

(a) County Genisicot 2 Registration District No. 653  
 (b) Township Bradfordia 1 Primary Registration District No. 2871 Registered No. 92  
 (c) City..... or..... (d) Street No..... St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME**

(a) Residence, No. Celest Ball - 110 St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>F</u>	4. COLOR OR RACE <u>Negro</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Ed Ball</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>May 2 1879</u>		
7. AGE	YEARS <u>60</u>	MONTHS <u>5</u>
	DAYS <u>17</u>	If LESS than 1 day, ..... hrs. or ..... min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.	
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>at home</u>	
	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) <u>Miss</u>		
FATHER	13. NAME <u>Unknown</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>	
MOTHER	15. MAIDEN NAME <u>Unknown</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>	
17. INFORMANT <u>Will Polk -</u> (ADDRESS) <u>Probler, Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Deering</u> DATE <u>10/15 39</u>		
19. FUNERAL DIRECTOR (NAME) <u>Frank Hayward</u> (ADDRESS) <u>Remick, Mo</u>		
20. FILED <u>10/14</u> 19 <u>39</u> <u>Pearl Kelley</u> Local Registrar		

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct - 14 1939  
 22. I HEREBY CERTIFY, That I attended deceased from Oct - 1, 1939 to Oct. 14, 1939  
 I last saw him alive on Oct. 4, 1939. Death is said to have occurred on the date stated above, at 9 a. m.  
 The principal cause of death and related causes of importance were as follows:

Cerebral apoplexy  
Left hemiplegia  
Senility  
Arteriosclerosis  
Hypertension  
 Date of onset

Other contributory causes of importance:  
 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?..... 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.....  
 (Signed) Asphrey, M. D.  
 (Address) Wayte, 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.

RECEIVED

District Health Officer No. 3,

District File No. 1139-651

Date Filed 11-10-39

---

**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**