

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.

APR 23 1940

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

11115
Do not use this space.

1. PLACE OF DEATH *Holt*
 (a) County *Holt* Registration District No. *372*
 (b) Township *Burlton* Primary Registration District No. *5118*
 (c) City _____ (d) Street No. _____ Registered No. *1034*
 (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 *Franklin Jasper Ball*
 (a) Residence, No. _____ 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 *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Divorced*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *no*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *May 14 1874*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
65 10 14

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

FATHER 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Holt County 0*
 13. NAME *James Ball 9*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown 9*

MOTHER 15. MAIDEN NAME *Mauda Brown*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

17. INFORMANT *G. J. Gaussee*
 (ADDRESS) *St. Joseph Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *St. Joseph Mo.* DATE *April 2 1940*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *W. H. Gaussee*
St. Joseph Mo.

20. FILED *ap 2 1940* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *March 31 1940*

22. I HEREBY CERTIFY, That I attended deceased from *March 31 1940* to *March 31 1940*
 I last saw him alive on *March 31 1940* Death is said to have occurred on the date stated above, at *2 P. M.*
 The principal cause of death and related causes of importance were as follows:

Rupture of liver
of spleen
accidentally crushed by
falling while loading
stock on farm

Other contributory causes of importance:
Torn ribs

Name of operation _____ Date of _____
 What test confirmed diagnosis? *autopsy* Was there an autopsy? _____

23. If death was due to external causes (violence) fill in also the following:
 Accident, suicide, or homicide? *Accident* Date of injury *3-31 1940*
 Where did injury occur? *Geo. Gaussee Farm*
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury *on farm*
 Nature of injury *see above*

24. Was disease or injury in any way related to occupation of deceased? *yes*
 If so, specify *Directly loading on farm*
 (Signed) *D. J. Gaussee* M. D.
 (Address) *St. Joseph Mo.*

Date of onset
2/10/40

RECEIVED
District Health Officer No. 111
District File Number 440-506
Date Filed APR 19 1940

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 W. C. Crawford
Licensed Embalmer No. 1824
P. O. Address Mound City, Mo.

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
STANDARD CERTIFICATE OF DEATH

State File No. 11115-

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 312

Primary Registration District No. 5578

Registrar's No. 1034

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Holt
(c) City or town New Market City Mo
(If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Franklin Jasper Ball

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced DW

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 10 14 _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant (b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) May 20 40 (b) Joe C. Tracy
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Mar day 31 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

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) _____

(b) Date of occurrence _____

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

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

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature D. C. Perry (M. D. or other)

Address New Market City Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

1940
S-11115