NOV 25 1940

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

35472
Do not use this space.

1. PLACE OF DEATH
(a) County Howell — Registration District No. 384
(b) Township Howell — Primary Registration District No. 5535 — Registered No.
(c) City or Town West Plains, Mo. (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. ... da. (f) How long in U. S., if of foreign birth? ... yrs. ... mos. ... da.

2. PRINT FULL NAME NAOMI MARIE BALDERSON
(a) Residence, No. West Plains, Mo. Siloams Springs Rt.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) |
|---|---|---|
| Female | White | Married |

5A. IF MARRIED, WIDOWED, OR DIVORCED — HUSBAND OF (OR) WIFE OF: Wm. Balderson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): March 10, 1909

| 7. AGE — YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or ...min. |
|---|---|---|---|
| 31 | 7 | 8 | |

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Springfield, Mo.

FATHER
13. NAME: Ira Hues
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown

MOTHER
15. MAIDEN NAME: Martha Bollinger
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri

17. INFORMANT (ADDRESS): Wm. Balderson, West Plains, Mo. Siloam Rt.

18. BURIAL, ~~CREMATION~~, OR ~~REMOVAL~~ PLACE: New Liberty DATE: Oct. 9 19 40

19. FUNERAL DIRECTOR (NAME) (ADDRESS): None

20. FILED 10-9- 1940 Vida W Simons Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): OCTOBER 8 1940

22. I HEREBY CERTIFY, That I attended deceased from Oct. 6, 1940, to Oct. 8, 1940
I last saw her E.R. alive on Oct. 8, 1940. Death is said to have occurred on the date stated above, at 9 P. m.
The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Abcess of Brain | Oct 5. |

Other contributory causes of importance:
Severe Cold

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? ... (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) P. O. Flynn, M. D.
(Address) West Plains, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

I X16605

RECEIVED
District Health Officer No. 5,
District File Number 1040/094
Date Filed

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**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 compl with the above constitutes grounds for revocation of license.)**

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

No. 2B
-2-21-40
P1 X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 35472

Registration District No. 384 — Primary Registration District No. 53 35 — Registrar's No.

1. PLACE OF DEATH:
(a) County Howell
(b) City or town Howell T. P.
(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 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(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 Naomi Marie Balderson
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced M
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 31 | Months 7 | Days 8 | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 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) (Date received by registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 8
year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.
Immediate cause of death Abscess of Brain — Duration
M. D.
Due to Middle ear
Due to Abscess
Other conditions Severe cold
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

23. Signature O. W. Gunn (M. D. or other)
Address West Plains Mo. Date signed 12/11/40

SUPPLEMENTARY