

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

14418

Do not use this space.

1. PLACE OF DEATH

(a) County Harrison Registration District No. 330
 (b) Township..... Primary Registration District No. 4197 Registered No.
 (c) City Bethany or..... (d) Street No. o. Bethany Hospital 977 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. 13 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Lamoni Ia St. Lamoni Ia Ia
 (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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lorena Ballantyne
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 6 1895

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
46 5 6

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farming
 9. Industry or business in which work was done, as saw mill, bank, etc. General
 10. Date deceased last worked at this occupation (month and year) Feb 25/42 11. Total time (years) spent in this occupation 30 yrs

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Soldier Iowa 1

FATHER 13. NAME R. A. Ballantyne

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Soldier, Ia 1

MOTHER 15. MAIDEN NAME Mary Berthalamew

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Preperation Iowa 1

17. INFORMANT (ADDRESS) Mrs Lorena Ballantyne Lamoni Iowa

18. BURIAL, CREMATION, OR REMOVAL PLACE Lamoni Ia DATE 3/12 1942

19. FUNERAL DIRECTOR (NAME) (ADDRESS) WHITE-MARSH FUNERAL CHAPEL Lamoni, Iowa

20. FILED 19..... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/12 1942

22. I HEREBY CERTIFY, That I attended deceased from 2-27 1942 to 3-12 1942
 I last saw him alive on 3-12 1942. Death is said to have occurred on the date stated above, at 9:25 a.m.
 The principal cause of death and related causes of importance were as follows:

Acute nephritis
12/11
 Other contributory causes of importance: ruptured appendix

Name of operation Appendectomy Date of.....
 What test confirmed diagnosis? Urinalysis 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?.....
 If so, specify.....
 (Signed) Arnold R. Spalding, Jr., M. D.
 (Address) Bethany, Ia

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 im-

FILED MAY 25 1942

41

500

MAY 10 1956

RECORDED

INDEXED

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 *Rollin S. White*
Licensed Embalmer No. *3895*
P. O. Address *Lamoni, Iowa*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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. 14418

Registration District No. 334

Primary Registration District No. 4197

Registrar's No. 25

1. PLACE OF DEATH:

(a) County..... Harrison

(b) City or town..... Bethany
(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 years, months or days)

In this community..... _____
years, months or days)

3. (a) PRINT FULL NAME..... James B Ballantyne

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

4. Sex..... m 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..... Oct 6 1895
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day min.

46 5 11 _____ min.

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

10. Usual occupation..... _____

11. Industry of business..... _____

MOTHER FATHER { 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) _____ (b) Date thereof..... _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... _____

18. (a) Signature of funeral director..... _____

(b) Address..... _____

19. (a) 4-23-1942 (b) Zelam. Burris
(Date received local registrar) (Registrar's signature)

Sup - (June 30 - 42)

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) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... mar Day..... _____
year..... 1942 hour..... _____ minute..... _____ M.

21. I hereby certify that I attended the deceased from.....
_____ 19.....
that I last saw him..... live on..... 19.....
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..... _____ (M. D. or other).....

Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

