

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

31021  
State File No. 323  
Registrar's No. 323

FILED OCT 8 1942

Registration District No. 274

Primary Registration District No. 3052

1. PLACE OF DEATH:

(a) County. Pettis  
(b) City or town. Sedalia  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Bothwell Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 2 weeks  
(Specify whether years, months or days)  
In this community. 15 years

3. (a) PRINT FULL NAME Mary Ellen Ball

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced. Wid. 9  
6. (b) Name of husband or wife. Geo. W. 6. (c) Age of husband or wife if alive years  
7. Birth date of deceased. Oct. 3 1863  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
78 11 13 hr. min.

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

10. Usual occupation. None

11. Industry or business.

12. Name Chas. Houseman

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

14. Maiden name. Martha Humphrey

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

16. (a) Informant. W. H. Ball

(b) Address. Sedalia, Mo.

17. (a) Burial (b) Date thereof. 9-17-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. Camp Branch

18. (a) Signature of funeral director. Geo. H. H. H.

(b) Address. Sedalia

19. (a) 9/17/42 (b) Mrs. Anna Berger  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State. Mo. (b) County. Pettis  
(c) City or town. Sedalia  
(If outside city or town limits, write "RURAL")  
(d) Street No. 309 East 3rd  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 16  
year 1942 hour 3 minute 05 A.M.

21. I hereby certify that I attended the deceased from 4  
Sept. 1942 to Sept. 16 1942  
that I last saw him alive on Sept. 15 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death. Duration

Branchial Pneumonia  
Hypostatic

Due to

Due to Fractured femur  
Surgical neck

Other conditions. (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) 132 V

(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. Sedalia, Mo. Date signed 9/17/42

RECEIVED

District Health Officer No. 8, :

District File Number.....

Date Filed 10-7-42

---

---

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..... *Geo. Liccardi*

Licensed Embalmer No. 3868

P. O. Address..... *Sedalia*

**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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 31021

Registration District No. 274

Primary Registration District No. 3052

Registrar's No. 223

1. PLACE OF DEATH:

- (a) County Pettis  
(b) City or town Sedalia  
(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)

3. (a) PRINT  
FULL NAME

Mary Ellen Ball

3. (b) If veteran,  
name war \_\_\_\_\_

3. (c) Social Security  
No. \_\_\_\_\_

4. Sex F

5. Color W  
race \_\_\_\_\_

6. (a) Single, widowed, married,  
divorced W

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years

7. Birth date of deceased Oct 3  
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

78

11

13

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) \_\_\_\_\_  
(Date received local registrar)

(b) \_\_\_\_\_

(Registrar's signature)

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 \_\_\_\_\_ Day \_\_\_\_\_  
year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_  
to \_\_\_\_\_, 19\_\_\_\_;  
that I observed him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Due to Hypostatic

Due to Fracture femur

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

1860

18

1860

18

1860

18

1860

18

1860

18

1860

18

1860

18

1860

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

SUPPLEMENTARY

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

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

- (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence Sept 2-42  
(c) Where did injury occur? Suburban Pitts mo  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
At Home (Specify type of place)  
While at work? Yes (e) Means of injury fall

23. Signature \_\_\_\_\_ (M. D. or other)

Address Sedalia

Date: signed 10/23/42

