

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **1511**

1. PLACE OF DEATH:

(a) County.....
 (b) City or town **St. Louis**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
4059 Lee Ave
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **None** (Specify whether
 In this community **50 Years**
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County.....
 (c) City or town **St. Louis**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **4059 Lee Ave**
 (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME **Robert Ballesty**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widower**
 6. (b) Name of husband or wife **Bridget Ballesty nee Dignam** 6. (c) Age of husband or wife if alive..... years
 7. Birth date of deceased **August 16, 1870**
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	72	5	29 hr. min.

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

10. Usual occupation **Retired**

11. Industry or business.....

MOTHER FATHER { 12. Name **James Ballesty**
 13. Birthplace **Unknown Ireland**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Ann Fullem**
 15. Birthplace **Unknown Ireland**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Val Schroeer**

(b) Address **4059 Lee Ave**

17. (a) **Burial** (b) Date thereof **2/18/43**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Math Hermann & Son**

(b) Address **2161 East Fair Ave**

19. (a) **FEB 16 1943** (b) **J. F. Buddecke**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **February** day **14th**
 year **1943** hour **7:55 AM** minute..... M.

21. I hereby certify that I attended the deceased from **Feb 14** 19**43**
 to **Feb 14** 19**43**
 that I last saw him alive on **Feb 13** 19**43**
 and that death occurred on the date and hour stated above.

Immediate cause of death.....
Chloroform

Due to.....
Chloroform

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **None**

Of autopsy.....

Duration

2 days

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?

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

23. Signature **J. F. Buddecke** (M. D. or other) **M.D.**

Address **5738 W. Elm** Date signed **2/16-43**

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

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..... *Francis A. Williamson*

Licensed Embalmer No. *3565*

P. O. Address *St Louis 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, fact should be so stated above.