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. 6504

FILED MAR 8 1943

Registration District No. 1

Primary Registration District No. 3025

Registrar's No. 21

1. PLACE OF DEATH:

(a) County: HOWELL

(b) City or town: WEST PLAINS
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: WEST PLAINS HOSPITAL
(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 .....

2. USUAL RESIDENCE OF DEACESED: 46

(a) State: NONE (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: 0

3. (a) PRINT FULL NAME: MARY JO 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: 0

6. (b) Name of husband or wife: —

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

7. Birth date of deceased: JANUARY (Month) 19 (Day), 1943 (Year)

8. AGE: Years 0 | Months 0 | Days 0 | If less than one day ..... hr. ..... min.

9. Birthplace: WEST PLAINS, (City, town, or county) MISSOURI (State or foreign country) 0

10. Usual occupation: NONE

11. Industry or business .....

FATHER
12. Name: EVERETT LAWRENCE BALL
13. Birthplace: BRANDSVILLE, (City, town, or county) MO. (State or foreign country) 0

MOTHER
14. Maiden name: OPAL ADAMS
15. Birthplace: HOWELL CO., (City, town, or county) MO. (State or foreign country) 0

16. (a) Informant: EVERETT L. BALL
(b) Address: WEST PLAINS, MO.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: JAN. 21, 1943 (Month) (Day) (Year)
(c) Place: burial or cremation: HOWELL VALLEY CEM. HOWELL TWP. HOWELL CO., MO.

18. (a) Signature of funeral director: Hal Thomburgh
(b) Address: WEST PLAINS, MO.

19. (a) 2-10-43 (Date received local registrar) (b) [illegible] (Registrar's signature)

1125

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ..... day ..... year ..... 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	Duration
Respiratory Failure	
Due to: Premature Birth 7 mo	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy:	

159

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): X

(b) Date of occurrence: X

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

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

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

23. Signature: Maurice Thompson (M. D. or other) M D

Address: West Plains Mo. Date signed: 1/27/43

RECEIVED
District Health Officer No. 5
District File Number 34328
Date Filed 3-5-43

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.

Not Embalmed

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.

. S. No. 2B
M—8-21-41
P I-X29288

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. 65-04

Registration District No. ____ Primary Registration District No. 3025 Registrar's No. ____

1. PLACE OF DEATH:
(a) County: Howell
(b) City or town: West Plains (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: West Plains Hosp (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 ____

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Howell
(c) City or town: West Plains (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 ____

3. (a) PRINT FULL NAME: Mary Jo Ball
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: S
6. (b) Name of husband or wife ____ 6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: Jan 19 — 1924 (Month) (Day) (Year)
8. AGE: Years ____ Months ____ Days ____ If less than one day: 6 hrs ____ 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 local registrar) (b) ____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Jan Day: 19 Year: 1943 Hour: ____ Minute: 4 A. 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	Duration
Respiratory failure	
Due to: Premature birth 7 mo	
Due to:	
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) ____
(b) Date of occurrence ____
(c) Where did injury occur? (City or town) (County) (State)
(b) 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 ____ (M. D. or other) ____
Address ____ Date signed ____

SUPPLEMENTARY