

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAR 9 1944

Registration District No. _____

Primary Registration District No. 6082

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Nelson Rural (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 4 Miles north of Nelson (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 11 years years, months or days

3. (a) PRINT FULL NAME James R. Ballard

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

4. Sex Male 5. Color or Race White 6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife Homie Ballard 6. (c) Age of husband or wife if alive 48 years
7. Birth date of deceased April 19th, 1878 (Month) (Day) (Year)

8. AGE: Years 65 Months 9 Days 25 If less than one day hr. _____ min. _____

9. Birthplace Saline County Missouri (City, town, or county) (State or foreign country)

10. Usual occupation Carpenter

11. Industry or business

12. Name Abner G. Ballard 13. Birthplace Kentucky (City, town, or county) (State or foreign country)

14. Maiden name Sarah Elizabeth 15. Birthplace Boone County Missouri (City, town, or county) (State or foreign country)

16. (a) Informant MRS. T. H. McRady (b) Address Nelson, Mo. Rural

17. (a) Burial (b) Date thereof Feb. 15, 1944 (Month) (Day) (Year)

(c) Place: burial or cremation Arrow Rock, Mo.

18. (a) Signature of funeral director Camille Lewis (b) Address Marshall, Mo.

19. (a) Feb. 15, 44 (b) Mrs. W. E. Shackelford (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline
(c) City or town Nelson, Rural (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 14 year 1944 hour 1 minute 0 M.

21. I hereby certify that I attended the deceased from Feb. 12, 1944 to Feb. 13, 1944 that I last saw him alive on Feb. 13, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death: Phthisis Pulmonalis Duration _____

Due to _____

Due to _____

Other conditions: 1361 (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy no

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) (e) Means of injury _____

23. Signature C. L. Lawless (M. D. or other) _____

Address Marshall Mo. Date signed 2-14-44

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

RECEIVED

County Health Officer No. 9,

County Health Officer

Date Filed 3-8-44

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, ~~and by~~.....

....., Registered Apprentice No.
working under my personal supervision.

Signed

Jan. H. Lewis

Licensed Embalmer No. 1171

P. O. Address. Marshall, 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.