

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11116

FILED APR 13 1944

Registration District No. 372

Primary Registration District No. 4228 5543

State File No.

Registrar's No. 121

1. PLACE OF DEATH:

(a) County Howard  
(b) City or town Rural (Booneslick Twp)  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution Home  
(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

Maxwell Ballew

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

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced  
6. (b) Name of husband or wife Laura B. Ballew 6. (c) Age of husband or wife if alive 27 years  
7. Birth date of deceased June 27, 1870  
(Month) (Day) (Year)

8. AGE: Years About 72 Months 8 Days 18 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Howard Co Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Martin Ballew  
13. Birthplace Howard Co Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Laura Lowe  
15. Birthplace Howard Co Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Norbert Ballew

(b) Address Armstrong, Mo

17. (a) buried (b) Date thereof 3-17-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rochell Cem.

18. (a) Signature of funeral director R. D. McCreary

(b) Address Glasgow, Mo

19. (a) 3-21-44 (b) McCreary  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Howard  
(c) City or town rural  
(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 March day 15  
year 1944 hour 6 minute 0 M.

21. I hereby certify that I attended the deceased from 3-14 1944 to 3-15 1944  
that I last saw him alive on 3-14 1944  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_  
Duration \_\_\_\_\_

myocarditis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Semility  
(Include pregnancy within 3 months of death)

Major findings: Of operations 93R

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)

(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 Dr. J. L. McCreary (M. D. or other) MD

Address Fayette, Mo Date signed 3-17-44

1319 (Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 4-12-49

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

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.