

No. 2  
8-43  
17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

15945

State File No. \_\_\_\_\_

FILED MAY 33 1944

Registration District No. 33 1044

Primary Registration District No. 6140

Registrar's No. 50

1. PLACE OF DEATH:

(a) County Shelby  
(b) City or town Clarence Rural Clay  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 2 yrs years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Shelby  
(c) City or town Clarence 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 30  
year 1944 hour \_\_\_\_\_ minute 30 P.M.

21. I hereby certify that I attended the deceased from March 30 1944 to March 30 1944  
that I last saw her alive on March 30 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic myocarditis Duration 3 yrs

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

Other conditions: Cerebral apoplexy 6 months  
(Include pregnancy within 3 months of death)

Major findings: 93d  
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)  
(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 D. L. Harlan MD (M. D. or other)  
Address Clarence Mo Date signed 5/3/44

3. (a) PRINT FULL NAME Maria Louisa Ballinger

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

4. Sex F 5. Color or race White 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Columbus Singleton (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased March 9 1851  
(Month) (Day) (Year)

8. AGE: Years 93 Months 9 Days 21  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Philadelphia Mo. 0  
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

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

12. Name Morris Gibbons

13. Birthplace Philadelphia Mo. 0  
(City, town, or county) (State or foreign country)

14. Maiden name Nancy Carmin

15. Birthplace Warren - Marion Mo. 0  
(City, town, or county) (State or foreign country)

16. (a) Informant Dr. Ballinger

(b) Address 653 N. HAWKINS - HANNIBAL

17. (a) burial (b) Date thereof April 1 - 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Linville Cemetery

18. (a) Signature of funeral director Keith Anderson

(b) Address 3rd St. Missouri

19. (a) April 1944 (b) W. H. G. G. G.  
(Date received local registrar) (Registrar's signature)

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

RECEIVED

District Health Officer No. 10

District File Number J-44-1000

Date Filed MAY 12 1944

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.