

FILED JUN 29 1944
Registration District No. _____

Primary Registration District No. **1002**

1. PLACE OF DEATH

(a) County **Jackson**
(b) City or town **Kennett**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Rebe Sade Hospital**
(If not in hospital or institution, write street number or location) **0**
(d) Length of stay: In hospital or institution **1 day**
In this community **2 days**
years, months or days

3. (a) PRINT FULL NAME **John A. Ballard**

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

4. Sex **M** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Dovie**
6. (c) Age of husband or wife if alive **50** years

7. Birth date of deceased **Jan 13 1884**
(Month) (Day) (Year)

8. AGE: Years **60** Months **4** Days **28**
If less than one day hr. min.

9. Birthplace **Hays, N.C.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Ever Green Worker**

11. Industry or business **Owner of Same**

12. Name **William Ballard**

13. Birthplace **North Carolina**
(City, town, or county) (State or foreign country)

14. Maiden name **Ellen Smart**

15. Birthplace **N. Carolina**
(City, town, or county) (State or foreign country)

16. (a) Informant **Archie Ballard**

(b) Address **Port Orchard Washington**

17. (a) **removal** (b) Date thereof **6/16/44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Port Orchard Wash.**

18. (a) Signature of funeral director **Jones - Meyhney**

(b) Address **2315 Denial**

19. (a) **6-17-44** (b) **N. C. Brown**
(Date received local register) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kennett**
(If outside city or town limits, write "RURAL")
(d) Street No. **3820 Street**
(If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **11** day **June**
year **1944** hour **minute** M.

21. I hereby certify that I attended the deceased from **19** to **19**;
that I last saw him **Reputy Coroner** and that death occurred on the date and hour stated above.

Immediate cause of death **Arteriosclerotic heart Disease.**

Due to **Disease.**

Due to **938**

Other conditions (Include pregnancy within 3 months of death) **938**

Major findings: Of operations **Inspection History**

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 **A. E. Walker** (M. D. or public health officer)
23 McCoy Date signed **6/16/44**

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

MOTHER FATHER

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 Ray E Snow
Licensed Embalmer No. 2560
P.O. Address 12 C 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.