

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

20469

State File No.

FILED JUN 29 1944

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2548

1. PLACE OF DEATH:

(a) County JACKSON
(b) City or town KANSAS CITY
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
7400 OLIVE STREET
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community 24 YEARS
(years, months or days)

3. (a) PRINT FULL NAME MRS. ELLEN SARAH BALSTON

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

4. Sex FEMALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife MR. MORGAN BALSTON
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased FEBRUARY 20 1858
(Month) (Day) (Year)

8. AGE: Years 86 Months 3 Days 27
If less than one day hr. _____ min. _____

9. Birthplace BRAMPTON - ONTARIO - CANADA
(City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business

12. Name WILLIAM RAYMOND
13. Birthplace CANADA
(City, town, or county) (State or foreign country)
14. Maiden name HARRIETTE CHURCH
15. Birthplace ENGLAND
(City, town, or county) (State or foreign country)

16. (a) Informant George Balston
(b) Address 7400 Olive Street

17. (a) BURIAL (b) Date thereof JUNE 19 1944
(Burial, cremation, or removal) PARALLEL CEMETERY
(c) Place: burial or cremation CLAY CENTER, KANSAS

18. (a) Signature of funeral director D.A. Newcomers Sons
(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 6-17-44 (b) N.E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON
(c) City or town KANSAS CITY
(If outside city or town limits, write "RURAL")
(d) Street No. 7400 OLIVE STREET
(If rural, give location)
(e) Citizen of foreign country? YES (Yes or No)
If yes, name country CANADA

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 17TH
year 1944 hour 1 minute 00 A.M.

21. I hereby certify that I attended the deceased from 1940 to JUNE 16 1944
that I last saw him alive on JUNE 16 1944
and that death occurred on the date and hour stated above.

Immediate cause of death
MIDDLE NERVE OF UTERUS
BLOODS 1 YR.

Due to 52 hr.

Other conditions CHARLES ALVARDOZ 1 YR.
(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)
(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 of Registrar A.C. [Signature]
(M. D. or other) [Signature]
Date 6-17-44

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

MOTHER FATHER

6944
1-4
Oscar
Linn

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 Emile M. Colborn

Licensed Embalmer No. 3506

P. O. Address K.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.