

FILED OCT 14 1944

State File No. ....

Registration District No. 170

Primary Registration District No. 3033

Registrar's No. ....

1. PLACE OF DEATH:

(a) County LACLEDE  
(b) City or town LEBANON  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
WALLACE HOSPITAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 WK. (Specify whether  
In this community ALWAYS years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County LACLEDE  
(c) City or town LEBANON 53  
(If outside city or town limits, write "RURAL")  
(d) Street No. 214 MORRIS ST. 1  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country FI

3. (a) PRINT FULL NAME

EMMA BALLARD

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced WIDOW

6. (b) Name of husband or wife

WM S. BALLARD

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased

JULY  
(Month)

7 1966  
(Day) (Year)

8. AGE:

Years 78

Months 2

Days 17

If less than one day  
hr. \_\_\_\_\_ min.

9. Birthplace

(City, town, or county)

IOWA

(State or foreign country)

10. Usual occupation

HOUSE WIFE

11. Industry or business

12. Name Thos. ANDERSON

13. Birthplace

(City, town, or county)

IOWA

(State or foreign country)

14. Maiden name

Sarah FOSTER

15. Birthplace

(City, town, or county)

TENN

(State or foreign country)

16. (a) Informant

Miss R. F. Crow

(b) Address

LEBANON Mo.

17. (a)

BURIAL  
(Burial, cremation, or removal)

(b) Date thereof

9-25-44  
(Month) (Day) (Year)

(c) Place: burial or cremation

LEBANON Mo.

18. (a) Signature of funeral director

PALMER'S

(b) Address

LEBANON Mo.

19. (a)

Sept. 28, 44  
(Date received local registrar)

(b) Grace Roper  
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT day 24  
year 1944 hour 4 minute A.M.

21. I hereby certify that I attended the deceased from  
6-30- 1944 to 9-24- 1944  
that I last saw EM alive on 9-23- 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death

CA stomach

Duration

(?)

Due to

Due to

Other conditions

(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

R. E. Harrell

(M. D. or other)

Address

Lebanon Mo

Date signed

9-26-44

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

MOTHER FATHER

Received

Laclede County Health Unit

File No.

9-44-123

Date Filed

10/11/44

NOV 29 1944

OCT 17 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

*W. B. Palmer*

Licensed Embalmer No. 1161

P. O. Address

*St. Louis 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.