

U.S. No. 2
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8967**

FILED APR 12 1945

Registration District No. **20**

Primary Registration District No. **5122**

Registrar's No. _____

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

1. PLACE OF DEATH:
 (a) County **Boone**
 (b) City or town **Stephens** *Rocky Fork Twp*
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
 (If not in hospital or institution, write street number or location) _____
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community **67 Years** (Specify whether)
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Boone**
 (c) City or town **Stephens**
 (If outside city or town limits, write "RURAL") _____
 (d) Street No. _____ (If rural, give location) _____
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **EVELYN BALLENGER**

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

4. Sex **Female** **5. Color or race** **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Everett Ballenger**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **8 - 2 - 1877**
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	67	7	16	hr. _____ min.

9. Birthplace **Boone County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business _____

MOTHER FATHER
12. Name **Lewis Shelnutt**
13. Birthplace **Unknown** **9**
 (City, town, or county) (State or foreign country)
14. Maiden name **Susan Blackburn**
15. Birthplace **Unknown** **9**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Everett Ballenger**

(b) Address **Stephens, Mo.**

17. (a) Burial **(b) Date thereof** **3-20-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Nashville Cemetery**

18. (a) Signature of funeral director *Barber Funeral Service*
(b) Address **Columbia, Mo.**

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Mar.** day **18**
year **1945** hour **3** minute **30** A. M.

21. I hereby certify that I attended the deceased from **March 14** 19**45** to **March 8** 19**45**
that I last saw him alive on **March 8** 19**45**
and that death occurred on the date and hour stated above.

Immediate cause of death **A. A. Paralysis**
Sarcoma
Due to **Hypertension**
Due to **no data**

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

Major findings: _____
Of operations **General**
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) **no**
(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 *J. B. Williams* (M.D. or other)
Address **Columbia, Mo.** **Date** **3/19/45**

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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

Thos L. Zaring

Licensed Embalmer No. *41321*

P. O. Address *Columbia, Md.*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. April
Registrar's No. _____

Registration District No. 40 Primary Registration District No. 5122

1. PLACE OF DEATH:
(a) County Boone
(b) City or town Stephens
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 7 yrs.
In this community 6 7 yrs.
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Evelyn Ballenger
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 m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug 2
(Month) (Day) (Year)

8. AGE: Years 67 Months 7 Days _____ If less than one day, _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business at home

MOTHER { 12. Name Stennis Shelmutt
13. Birthplace Wich (City, town, or county) (State or foreign country)
14. Maiden name Susan (City, town, or county) (State or foreign country)
15. Birthplace Wich (City, town, or county) (State or foreign country)

16. (a) Informant Wendy Ballenger

(b) Address Stephen MO

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-45
(Month) (Day) (Year)

(c) Place: burial or cremation Nashville cemetery

18. (a) Signature of funeral director Parker F. Hamel

(b) Address Columbia, Miss

19. (a) 3-19 (Date received local registrar) (b) Ruby West (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Boone
(c) City or town Stephens
(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 Mar day 18
year 1945 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death paralysis stroke

Due to Hypertension
Due to no data
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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 _____ (M. D. or other) _____
Address _____ Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

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