

FILED AUG 31 1945

State File No.

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Montgomery
(b) City or town Montgomery City Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. (Specify whether)
In this community _____
years, months or days

3. (a) PRINT FULL NAME JAMES FRANKLIN BALL

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

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife ALICE BALL 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased FEB 2 1855
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
90 5 4 hr. min.

9. Birthplace Lincoln Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Lawyer

11. Industry or business

MOTHER FATHER { 12. Name John E Ball
13. Birthplace Virginia State
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Dyer
15. Birthplace Virginia State
(City, town, or county) (State or foreign country)

16. (a) Informant James Morris
(b) Address St Louis Mo
17. (a) Burial (b) Date thereof July 8 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Montgomery City Cemetery

18. (a) Signature of funeral director James Morris

(b) Address Montgomery City Mo

19. (a) July 13/45 (b) Mo C E Dyer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Montgomery
(c) City or town Montgomery City Mo
(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 _____

MEDICAL CERTIFICATION

23. DATE OF DEATH: Month July day 6
year 1945 hour 4 minute 0 P. M.

21. I hereby certify that I attended the deceased from _____, 1945 to _____, 1945
that I last saw him alive on 7/6
and that death occurred on the date and hour stated above.

Immediate cause of death Fracture Hip Duration 6 days

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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) 7th
(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 Dyer (M. D. or _____)
Address Wendover Mo Date signed 7/14/45

RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed 8-2-45

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. 3658

P. O. Address Montgomery City

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. *Aug*Registration District No. *231*Primary Registration District No. *4346*Registrar's No. *228*

1. PLACE OF DEATH:

- (a) County *Montgomery*
(b) City or town *Montgomery*
(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 years, months or days)

3. (a) PRINT
FULL NAME*James F. Ball*

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

4. Sex *M* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *wid*
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive
7. Birth date of deceased *Feb 2*
(Month) (Day) (Year)

8. AGE: Years *90* Months *5* Days *4* If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant

- (b) Address

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

- (c) Place: burial or cremation

18. (a) Signature of funeral director

- (b) Address

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

2. USUAL RESIDENCE OF DECEASED:

- (a) State (b) County
(c) City or town (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 *Aug* Year *1945* Hour *10* minute *00* M.

21. I hereby certify that I attended the deceased from *10* to *19*;
that I last saw him *alive* on *19*;
and that death occurred on the date and hour stated above.
Immediate cause of death

Due to *Fall in home*

Due to

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) *Accident - Fall in home*
(b) Date of occurrence *6-30-45*
(c) Where did injury occur? *in home* (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) *Fall + broke leg* (e) Means of injury23. Signature *J. H. Byland* (M. D.)Address *Wellshire Mo* Date signed *8/9/45*

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

S-24509