

S. No. 2
MOM-5-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

FILED AUG 22 1945

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3291

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution 704 N 35 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 yrs.
(Specify whether years, months or days)

In this community 10 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City Mo
(If outside city or town limits, write "RURAL")

(d) Street No. 704 N 35
(If rural, give location)

(e) Citizen of foreign country? 0
(Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME Angeline Snow Ballard

3. (b) If veteran, name war none

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 3
year 1945 hour 12 minute 25 P.M.

21. I hereby certify that I attended the deceased from 9-11, 1943 to 8-3, 1945
that I last saw her alive on 8-3-45, 1945
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color of race Wh

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

6. (c) Age of husband or wife if alive 15 years

7. Birth date of deceased June 15 1861
(Month) (Day) (Year)

Immediate cause of death Hyper-tension
Cardio-vascular disease
Acute myocardial failure

Duration 10 yrs
2 days

8. AGE: Years 84 Months 1 Days 18
If less than one day hr. min.

Due to Arterio-sclerosis 20 yrs?

Due to

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

10. Usual occupation Housework

Other conditions (Include pregnancy within 3 months of death) 131a

MOTHER FATHER

11. Industry or business

12. Name David Miller

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

14. Maiden name Ann McEats

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

Major findings: Of operations 131a

Of autopsy

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

16. (a) Informant Allice B. Shipman

(b) Address 704 N 35

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

17. (a) Removed (b) Date thereof Aug-7-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Liberty Cem. Mandeville Mo

(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?.....

18. (a) Signature of funeral director Mr. W. H. Foster

(b) Address 918 Brooker

19. (a) 8-6-45 (b) Steraldine Holmes
(Date received local registrar) (Registrar's signature)

While at work? (Specify type of place).....

(c) Means of injury 0

23. Signature E. L. Petry (M. D. or other).....
Address 300 Argyle Bldg. Date signed 8-4-45

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

18
23
8

Angyle Boddy
Rt 5997

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.....

Orlando Minic

Licensed Embalmer No.....

3414

P. O. Address.....

918 Brooklyn

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.