

S. No. 2  
M-8-43  
5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

FILED DEC 8 1945

STANDARD CERTIFICATE OF DEATH

State File No. 37371

Registration District No. 140

Primary Registration District No. 5542

Registrar's No. 80

58  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County HOWARD

(b) City or town RURAL 6 miles  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: COUNTY POOR FARM  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 years  
(Specify whether years, months or days)

In this community 576 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howard

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

(d) Street No. 12 miles N.E. Fayette Mo  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME LEE BALLEW

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV day 22  
year 1945 hour 3:30 minute P M.

21. I hereby certify that I attended the deceased from 11-1-45  
to 11-22-45

that I last saw him alive on 11-20-45  
and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced divorced

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

7. Birth date of deceased: May 15 1869  
(Month) (Day) (Year)

Immediate cause of death Uremia Coma 12 hr  
Chronic Cardiac - Vascular Renal disease 1 yr

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Enlarged Prostate  
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day

76 6 7 hr. min.

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

10. Usual occupation Elevator Operator

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy 12/10

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

11. Industry or business Hotel

12. Name Harvey Ballew

13. Birthplace Unknown U.S.A.  
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Jacks

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

16. (a) Informant Oady Ballew

(b) Address 1905 Hardesty K.C. Mo

17. (a) Burial (b) Date thereof: Nov 24 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Glasgow Mo.

18. (a); Signature of funeral director Ardeley-Friemuth

(b) Address Glasgow Mo.

19. (a) 11-24-45 (b) Ardeley-Friemuth  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

Signature W. B. Bloom (M. D. or other) M.D.

Address Fayette Mo Date signed 11-24-45

1531 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 12-7-41

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 J. Walker Audsley  
Licensed Embalmer No. 3336  
P. O. Address Glasgow 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.