

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33439**
4353
Registrar's No.

FILED OCT 28 1946

Registration District No. **11** Primary Registration District No. **1002**

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

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **16 days**
(Specify whether
In this community **Unknown**
years, months or days)

3. (a) PRINT FULL NAME **Charles Ballard**
3. (b) If veteran, name war **Unknown** 3. (c) Social Security No. **Unknown**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Unknown** 6. (c) Age of husband or wife if alive **UNK** years
7. Birth date of deceased **Dec. 13 1881**
(Month) (Day) (Year)

8. AGE: Years **64** Months **9** Days **22** If less than one day hr. min.

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

10. Usual occupation **Unknown**

11. Industry or business

MOTHER FATHER
12. Name **Christopher Ballard**
13. Birthplace **Ill.** (City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown** (City, town, or county) (State or foreign country)

16. (a) Informant **Record Clerk**
(b) Address **K.C. General Hosp #1**

17. (a) **Anatomical** (Burial, cremation, or removal) (b) Date thereof **10-17-46**
(Month) (Day) (Year)
(c) Place: burial or cremation **Dental College: U.K.C.**

18. (a) Signature of funeral director **Weilert Funeral Home**
(b) Address **K.C. Mo.**

19. (a) **10-17-46** (Date received local registrar) (b) **Sheraldine Holmes** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **3105 E. 12 St.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Oct.** day **5**
year **1946** hour **6** minute **8 P.** M.
21. I hereby certify that I attended the deceased from **Sept. 19 1946** to **Oct. 5 1946**
that I last saw him alive on **Oct. 5 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral vascular accident**
Due to
Due to
Other conditions (include pregnancy within 3 months of death) **830**
Major findings: Of operations
Of autopsy **None**
Duration
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 **Wm W Hart** (M. D. or other) **MD**
Address **Med. Dir. Gen'l Hosp.** Date signed **10-16-46**

Dr. Cashman

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..... *Blaine E. Walcutt*

Licensed Embalmer No. *4075*

P. O. Address..... *K.C. 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.