

FILED JAN 14 1947

State File No. _____

Registration District No. 184

Primary Registration District No. 3038

Registrar's No. 235

1. PLACE OF DEATH:
 (a) County Brookfield
 (b) City or town Brookfield
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: M. Larney's
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 hrs.
 (Specify whether _____)
 In this community _____
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State mo (b) County Brookfield
 (c) City or town Brookfield
 (If outside city or town limits, write "RURAL")
 (d) Street No. 116 Market St
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Frank Edward Ballard
 (b) If veteran, name war ✓
 (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Dec day 17
 year 1946 hour 3 minute 10 P.M.
 21. I hereby certify that I attended the deceased from 12-17
11 1946, to 12-17 1946
 that I last saw h. in alive on 12-17 1946
 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 widowed
 6. (b) Name of husband or wife Mary Ethel Collyer
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Feb 1 1898
 (Month) (Day) (Year)

Immediate cause of death Cerebral vascular accident Duration 3 hrs
 Due to Generalized arteriosclerosis
and Hypertension
 Due to _____

8. AGE: Years Months Days If less than one day
48 10 16 _____ hr. _____ min.

9. Birthplace Morgan Hill California
 (City, town, or county) (State or foreign country)

10. Usual occupation Laborer Highway Dept

11. Industry or business _____

12. Name Nathaniel Ballard

13. Birthplace Ill. 1
 (City, town, or county) (State or foreign country)

14. Maiden name Sarah Rawls

15. Birthplace Ill. 1
 (City, town, or county) (State or foreign country)

16. (a) Informant Hazel Ballard

(b) Address Brookfield mo

17. (a) Burial (b) Date thereof Dec 20 1946
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Michaels Brookfield

18. (a) Signature of funeral director James M. Douglas

(b) Address Marshall mo

19. (a) 17 1/16 (b) Walter Brown
 (Date received local registrar) (Registrar's signature)

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:
 (c) 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?
 (Specify type of place) (e) Means of injury _____

23. Signature Joseph W. Babinski (M. D. or other) _____
 Address Brookfield Date signed 12-21-46

MOTHER FATHER

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

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 *Blanche M Langhew*
Licensed Embalmer No. *1909*
P. O. Address *Marceline*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. *Jan*Registration District No. *184*Primary Registration District No. *3039*Registrar's No. *231-*

1. PLACE OF DEATH:

- (a) County *Lincoln*
 (b) City or town *Brookfield* *Marion*
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
MAE CLARK
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution? *3 days*
 (Specify whether
 In this community *Y*
 years, months or days)

3. (a) PRINT
FULL NAME *Frank E. Ballard*3. (b) If veteran,
name war3. (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
alive7. Birth date of deceased *Feb 1*
(Month) (Day) (Year)8. AGE: Years Months Days
48 *4* *4* If less than one day
hr. min.9. Birthplace *California*
(City, town, or county) (State or foreign country)10. Usual occupation *Supv. Highway Dept.*

11. Industry or business

MOTHER FATHER { 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) *Walter B. Cowie*
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State *MO* (b) County *Lincoln*
 (c) City or town *Brookfield*
 (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 *Jan* 19*46*
year *1946* hour *11* minute *17* M.21. I hereby certify that I attended the deceased from
19*46* to 19*46*
that I last saw him *and* alive on
and that death occurred on the date and hour stated above.
Immediate cause of death

Duration

Duration

Due to

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)
 (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

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

SUPPLEMENTARY

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

41290