V. S. No. 2
0M—1/47
Rev. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED APR 23 1947

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15924

Registration District No. 317 | Primary Registration District No. 6076 | Registrar's No. 892

1. PLACE OF DEATH:
(a) County: St. Louis
(b) City or town: Jennings
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Elms Nursing Home – 2520 McLaren
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: St. Louis
(c) City or town: Jennings
(If outside city or town limits, write "RURAL")
(d) Street No.: 2520 McLaren Ave.
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: Nora M. Ball
3. (b) If veteran, name war: No
3. (c) Social Security No.: None
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widow
6. (b) Name of husband or wife: Benjamin F. Ball
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: March (Month) 1 (Day) 1870 (Year)
8. AGE: Years 77 | Months 1 | Days 17 | If less than one day ..... hr. ..... min.
9. Birthplace: Indiana (City, town, or county) (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business .....
FATHER 12. Name: Henry H. Sickles
13. Birthplace: Indiana (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Lucinda E. Hyatt
15. Birthplace: Ohio (City, town, or county) (State or foreign country)
16. (a) Informant: C. D. Sickles
(b) Address: 4165 Flad Ave.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 4-18-47 (Month) (Day) (Year)
(c) Place: burial or cremation: Cheyanne, Wyoming
18. (a) Signature of funeral director: Albert H. Hoppe
(b) Address: 4700 Washington Blvd.
19. (a) 4-18-47 (Date received local registrar) (b) Cecil A. Sharpe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 17 year 1947 hour 10 minute 05 A.M.
21. I hereby certify that I attended the deceased from Feb 2, 1946 to April 17, 1947; that I last saw her alive on April 16, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic Myocarditis	2 yrs?
Due to: 93 D	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy:	

PHYSICIAN — Underline the cause of 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? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....
23. Signature: Eugene L. Arnold (M. D. or other) M.D.
Address: 1449 McLaran Date signed: 4/18/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 Henry W. Brammer

Licensed Embalmer No. 4200

P. O. Address St. Louis 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.