S. No. 2
M—8-43
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 25 1947
Registration District No. 937

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37886
State File No.
Primary Registration District No. 3023
Registrar's No. 238

1. PLACE OF DEATH:
(a) County Henry (Clinton)
(b) City or town
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Whitted Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 Hours (Specify whether
In this community years, months or days)

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

3. (a) PRINT FULL NAME Sherry Belle BAllard
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 11 (Month) 15 (Day) 47 (Year)

8. AGE: Years | Months | Days | If less than one day 5 hr. min.

9. Birthplace Clinton (City, town, or county) Mo 0 (State or foreign country)
10. Usual occupation
11. Industry or business

MOTHER FATHER
12. Name William R. Ballard
13. Birthplace St Clair Co (City, town, or county) Mo 0 (State or foreign country)
14. Maiden name Shirley Cook
15. Birthplace (City, town, or county) Arkansas (State or foreign country)

16. (a) Informant William Ballard
(b) Address Osceola Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-47 (Month) (Day) (Year)
(c) Place: burial or cremation Lakeside Cemetery
18. (a) Signature of funeral director F B Goodrich
(b) Address Osceola Mo
19. (a) 11-16-47 (Date received local registrar) (b) R R Kenny (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 15 year 47 hour 10 minute 10 P.M.
21. I hereby certify that I attended the deceased from Birth, Last I death, 19..., to ..., 19...;
that I last saw h... alive on ..., 19...;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Premature	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature G B Doman (M. D. or other)
Address Osceola City Mo Date signed 11-16-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number ----------
Date Filed ----------

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. Not Embalmed

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.