No. 2
1-47
17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED APR 14 1948

Registration District No.

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5000

State File No. 7689

Registrar's No. 108

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

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Rural, Kirksville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: R.F.D. #3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Adair
(c) City or town Rural, Kirksville
(If outside city or town limits, write "RURAL")
(d) Street No. R.F.D. #3
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME NANCY JANE BALLINGER
3. (b) If veteran, name war .....
3. (c) Social Security No. .....
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Milton Ballinger
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased ..... (Month) ..... (Day) 1860 (Year)

8. AGE: Years 87 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) ..... (State or foreign country)
10. Usual occupation Housewife
11. Industry or business .....
FATHER
12. Name James Williams
13. Birthplace Callao (City, town, or county) Mo. (State or foreign country)
MOTHER
14. Maiden name ~~Herbert Ballinger~~
15. Birthplace ~~Naunger R.F.D. #1~~ (City, town, or county) (State or foreign country)
16. (a) Informant Herbert Ballinger
(b) Address Naunger Mo R.F.D. #1
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21-48 (Month) (Day) (Year)
(c) Place: burial or cremation Sloans Point Cemt.
18. (a) Signature of funeral director Davis Funeral Home
(b) Address Kirksville
19. (a) 4-5-48 (Date received local registrar) (b) Kate Lambert (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 20" year 1948 hour 6 minute 0 A.M.

21. I hereby certify that I attended the deceased from ..... 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 Cerebral Hemorage	
Due to	
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 Foster R. Easley (M.D. or other) Coroner
Address Brashear, Mo. Date signed 3-20-48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 4-48-683
APR 12 1948
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 Not Embalmed Registered Apprentice No. working under my personal supervision.

Signed Clarence M. Bills

Licensed Embalmer No. 4375

P. O. Address Kirksville, 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.

No. 2B
3-45
X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. April

Registration District No. 1 Primary Registration District No. 5000 Registrar's No. 103

1. PLACE OF DEATH:

(a) County Adair

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

(c) Name of hospital or institution:
(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 (b) County

(c) City or town
(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

3. (a) PRINT FULL NAME Nancy J. Ballinger

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 wid

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive Years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 87 Months Days If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) Kate Lambert (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day year hour minute M.

21. I hereby certify that I attended the deceased from to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

Reported 4-21-48

1948
S-7689