

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUN 15 1949

15617

State File No. 464 A

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

30

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>5466</u>		Registrar's No. <u>464 A</u>			
1. PLACE OF DEATH a. COUNTY <u>GREENE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>North Carolina</u> b. COUNTY <u>Catawba</u>					
b. CITY (If outside corporate limits, write RURAL and give township) <u>TOWNS. Campbell Twp. RURAL</u>		c. LENGTH OF STAY (In this place) <u>1yr, 4mos, 2days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Hickory</u>		31			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>US Medical Center for Fed. Pris.</u>				d. STREET ADDRESS (If rural, give location) <u>9, 901 Holly St.</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Ballard</u> b. (Middle) _____ c. (Last) <u>MARTIN</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>May '26 1949</u>						
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>October 29, 1922</u>	9. AGE (In years last birthday) <u>26</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None known</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Rhode Hills, North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>			
13a. FATHER'S NAME <u>Robert Martin</u>		13b. MOTHER'S MAIDEN NAME <u>Beessie Louise Warlick</u>		14. NAME OF HUSBAND OR WIFE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>File - MCFP * Springfield, Missouri</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bacteremia, tuberculous</u>				DUE TO (b) <u>Post-Operative right pneumonectomy</u>				<u>7 days</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>				DUE TO (c) <u>Pulmonary tuberculosis, far advanced</u>				<u>2 years</u>	
19a. DATE OF OPERATION <u>5-19-49</u>		19b. MAJOR FINDINGS OF OPERATION <u>Far adv. tuberculosis right lung and mediastinum</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>S. Campbell Twp. Greene Missouri</u>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that <u>the medical staff</u> attended the deceased from <u>January 24 1948</u> , to <u>May 26, 1949</u> , that <u>they</u> last saw the deceased alive on <u>May 26, 1949</u> , and that death occurred at <u>6:45 A.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>J. H. Hanson</u> Acting Clinical Director				23b. ADDRESS <u>Medical Center for Federal Prisoners, Springfield,</u>		23c. DATE SIGNED <u>5-26-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>May 26 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>?</u>		24d. LOCATION (City, County) (State) <u>Hickory, N Carolina</u>			
DATE REC'D BY LOCAL REG. <u>6/2/49</u>		REGISTRAR'S SIGNATURE <u>W. E. Handley, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Fred C. Thieme Springfield</u>					

(Licensed Embalmer's Statement on Reverse Side)

10 May

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed Frederic Thiem

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 2899

P. O. Address Springfield, 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.