

FILED MAY 5 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13712

BIRTH NO. _____ REG. DIST. NO. 185 PRIMARY REG. DIST. NO. 5692e Registrar's No. 4

580

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

1. PLACE OF DEATH a. COUNTY <u>Linn</u> b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>5 miles S Meadville</u> c. LENGTH OF STAY (in this place) <u>Life</u> d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>5 miles S Meadville</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u> c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Meadville, Mo. 0580</u> d. STREET ADDRESS (If rural, give location) <u>5 miles S Meadville Mo</u>	
3. NAME OF DECEASED (Type or Print) <u>Nannie E. Balcom</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>4-15-1950</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Mar 27, 1859</u>
9. AGE (In years last birthday) <u>91</u>	# UNDER 1 YEAR Months <u>—</u> Days <u>18</u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY _____
11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Elbridge Clough</u>		13b. MOTHER'S MAIDEN NAME <u>Letitia Sarsentaffin</u>	
14. NAME OF HUSBAND OR WIFE <u>W. A. Balcom</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Lloyd Balcom, Meadville, Mo.</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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic myocarditis</u>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) _____	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (c) _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
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) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		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 I attended the deceased from <u>Feb</u> , 19 <u>48</u> , to <u>April 15</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>March</u> , 19 <u>50</u> , and that death occurred at <u>7:00 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Joseph F. Gell, M.D.</u>		23b. ADDRESS <u>Chillicothe, Mo.</u>	
23c. DATE SIGNED <u>4-18-50</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>4-17-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Laclede Cemetery</u>	
24d. LOCATION (City, town, or county) (State) <u>Laclede, Missouri</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Brothers Funeral Home</u>	
DATE REC'D BY LOCAL REG. <u>Apr. 17-1950</u>		REGISTERAR'S SIGNATURE <u>Christ. Martens</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Brothers Funeral Home</u>		ADDRESS <u>Laclede, Mo</u>	

STATE OF MISSOURI
DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS

DATE OF DEATH

(Year) (Mo.) (Day)

PLACE HERE
IF DEATH OCCURRED
IN A FOREIGN
COUNTRY
OR IN A
CITY OR VILLAGE
NOT IN THIS STATE

OFFICE

ADDRESS

DEATH AND BURIAL
OFFICE



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 _____

CITY TOWN VILLAGE

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed W R Wright

Licensed Embalmer No. 4653

P. O. Address Camden, 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.