

No. 300  
10-48

FILED MAY 5 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **15499**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **324** PRIMARY REG. DIST. NO. **3072** Registrar's No. **87**

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

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Saline</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b> b. COUNTY <b>Saline</b> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Marshall, Mo.</b> |  | c. LENGTH OF STAY (In this place) <b>4 1/2 Yrs.</b>  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>409 North Odell</b>                                    |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Marshall</b>   |  |
|   |  | d. STREET ADDRESS (If rural, give location) <b>409 North Odell</b>   |  |

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>Henry</b> b. (Middle) <b>Martin</b> c. (Last) <b>Ballinger</b>  |  |   | 4. DATE (Month) (Day) (Year) OF DEATH <b>April 21-1950</b> |  |  |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>White</b>                           |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>                      |  |
| 8. DATE OF BIRTH <b>April 2-1865</b>   |  | 9. AGE (In years last birthday) <b>85</b>               |  | IF UNDER 1 YEAR: Months <b>0</b> Days <b>19</b> IF UNDER 1 HRS. Hours <b></b> Min. <b></b> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate Owner</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Retired Farmer</b> |  | 11. BIRTHPLACE (State or foreign country) <b>Greenfield-Missouri</b>                       |  |
|  |  |   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 13a. FATHER'S NAME <b>William E. Ballinger</b> |  | 13b. MOTHER'S MAIDEN NAME <b>Agnes Bibb</b> |  | 14. NAME OF HUSBAND OR WIFE <b>Hattie A. Ballinger-Deceased</b> |  |
|--|--|---|--|---|--|

|   |  |                                     |  |  |  |
|---|--|-------------------------------------|--|--|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b> |  | 16. SOCIAL SECURITY NO. <b>None</b> |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Josephine Young-Marshall-MO.</b> |  |
|---|--|-------------------------------------|--|--|--|

|  |  |  |  |  |                                  |
|--|--|--|--|--|----------------------------------|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)   |  | MEDICAL CERTIFICATION  |  |  | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Paraplegia</b>   |  | ANTECEDENT CAUSES  |  |  | <b>4 wk</b>                      |
| *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. |  | Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. |  |  | <b>?</b>                         |
| DUE TO (b) <b>Hypertension</b>   |  | DUE TO (c)   |  |  | <b>334X</b>                      |
| II. OTHER SIGNIFICANT CONDITIONS   |  | Conditions contributing to the death but not related to the disease or condition causing death.  |  |  |                                  |

|  |  |                                  |  |  |  |  |
|--|--|----------------------------------|--|--|--|--|
| 19a. DATE OF OPERATION <input checked="" type="checkbox"/> |  | 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 **Jan 2, 1950**, to **April 21, 1950**, that I last saw the deceased alive on **April 19, 1950**, and that death occurred at **2:26 p.m.**, from the causes and on the date stated above.

|   |  |                              |  |                                 |  |
|---|--|------------------------------|--|---------------------------------|--|
| 23a. SIGNATURE <b>[Signature]</b> (Degree or title) <b>M.D.</b> |  | 23b. ADDRESS <b>Marshall</b> |  | 23c. DATE SIGNED <b>4/24/50</b> |  |
|---|--|------------------------------|--|---------------------------------|--|

|  |  |                          |  |   |  |
|--|--|--------------------------|--|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b> |  | 24b. DATE <b>4/23/50</b> |  | 24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Pleasant</b>                  |  |
|  |  |                          |  | 24d. LOCATION (City, town, or county) (State) <b>Richmond, Missouri</b> |  |

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| DATE REC'D BY LOCAL REG. <b>April 24, 1950</b> |  | REGISTRAR'S SIGNATURE <b>Bidney J. Gray</b> <b>385</b> |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>[Signature]</b> |  |
|--|--|--|--|---|--|

RECEIVED MAY 1  
District Health Officer No. 8,  
District File Number \_\_\_\_\_  
Date Filed 5/4/50

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.

Student .....  
Student Embalmer

Signed J. Leslie Swenson

Licensed Embalmer No. 3235

P. O. Address Marshall

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.