

FILED JAN 15 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41672

State File No.

No. 300
10.48

BIRTH NO. _____ REG. DIST. NO. 265 PRIMARY REG. DIST. NO. 5876 Registrar's No. 19

1. PLACE OF DEATH a. COUNTY <u>Ozark</u>		2. USUAL RESIDENCE (Where deceased lived. Institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Ozark</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Albia</u>		c. LENGTH OF STAY (In this place)	
d. FULL NAME OF (If not hospital or institution, give street address or location)		c. CITY (If outside corporate limits, write RURAL and give township) <u>Albia</u>	
d. STREET ADDRESS (If rural, give location) <u>0</u>		d. STREET ADDRESS (If rural, give location) <u>0</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Simon</u> b. (Middle) <u>Franklin</u> c. (Last) <u>Ballingew</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>10-28-50</u>	
5. SEX <u>Mo</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>M.</u>	8. DATE OF BIRTH <u>1-29-1880</u>
9. AGE (In years last birthday) <u>70</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Douglas Co Mo</u>
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME <u>Mrs. Ballinger</u>	
13b. MOTHER'S MAIDEN NAME <u>Margaret Parsons</u>		14. NAME OF HUSBAND OR WIFE <u>Thos Ballinger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME <u>Thos Ballinger, Albia Mo.</u>		17. ADDRESS	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac Decompensation</u> ANTECEDENT CAUSES DUE TO (b) <u>Arterial hypertension</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>443X</u>	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>3 Mo</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input 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?		21g. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>50</u> , to <u>Oct 28</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>Oct 15</u> , 19 <u>50</u> , and that death occurred at <u>7:15 a.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>M J Hoerman 2nd</u>		23b. ADDRESS <u>Gainesville Mo</u>	
23c. DATE SIGNED <u>11-29-50</u>		24a. BURIAL, CREMATION, REMOVAL (Specify)	
24b. DATE <u>10-30-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Trail Cem.</u>	
24d. LOCATION (City, town, or county) (State) <u>Ozark Co. Mo.</u>		24e. LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <u>12-30-50</u>		REGISTRAR'S SIGNATURE <u>Mae Johnson</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Robertson's Rest Plains Mo.</u>		25. ADDRESS	

0190

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

DIVISION OF HEALTH OF MO.

District No. 5 - Springfield

RECEIVED DEC 27 1950

Dist. File _____

Date Filed _____

DIVISION OF HEALTH OF MO.

District No. 5 - Springfield

RECEIVED JAN 6 1951

Dist. File 157-66

Date Filed 1-8-51

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 _____

Signed _____
Student Embalmer

Licensed Embalmer No. X. J. Magno
4547

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.