

FILED AUG 22 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25482

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

REG. DIST. NO. 47

PRIMARY REG. DIST. NO. 3088

Registrar's No. 221

1. PLACE OF DEATH a. COUNTY <u>CALLAWAY</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>CALLAWAY</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>FULTON</u>		c. LENGTH OF STAY (In this place) <u>3 MONTH</u>	c. CITY OR TOWN <u>FULTON</u>		d. In Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>CALLAWAY HOSPITAL</u>			e. STREET ADDRESS (If rural, give location) <u>808 W. JEFFERSON 01420</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>ANNIE</u> b. (Middle) <u>MARIE</u> c. (Last) <u>BALLMEIER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>AUGUST 17, 1955</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>APRIL 26, 1871</u>	9. AGE (In years last birthday) <u>84</u>	10. F UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>TEICH GRABER</u>		13b. MOTHER'S MAIDEN NAME <u>ANTONIA FISCHER</u>		14. NAME OF HUSBAND OR WIFE <u>CARL C. BALLMEIER</u>	
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>No</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Laura Ballmeier Jefferson City 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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hemiplegia, left</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>gangrene of rt. foot only</u>				INTERVAL BETWEEN ONSET AND DEATH <u>over 5/13/55</u>  <u>years</u>  <u>12 weeks</u>
19a. DATE OF OPERATION <u>—</u>	19b. MAJOR FINDINGS OF OPERATION <u>none</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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>5/13/55</u> , 19 <u>55</u> , to <u>8/17</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8/17</u> , 19 <u>55</u> , and that death occurred at <u>2:30P</u> m., from the causes and on the date stated above.					
23a. SIGNATURE (In type or title) <u>Nancy D. Smith, M.D.</u>			23b. ADDRESS <u>Fulton, Mo.</u>		23c. DATE SIGNED <u>8/18/55</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>208 19, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>MT CARMEL</u>	24d. LOCATION (City, town, or county) (State) <u>CALLAWAY COUNTY MO</u>		
DATE REC'D BY LOCAL REG. <u>Aug 20-1955</u>	REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Marjorie Turner</u>		ADDRESS <u>Home Fulton Mo</u>

(Licensed Embalmer's Statement on Reverse Side)

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

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**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.....  
Signature of Student Embalmer

Signed *Glen Y. Magnus*.....

Licensed Embalmer No. *270*.....

P. O. Address *Fulton,*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.