

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 24 1956

State File No. **28088**
Registrar's No. **6701**

BIRTH NO. **49017-56** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Maternity		e. STREET ADDRESS (If rural, give location) 21 2823 Sheridan Avenue 2219	

3. NAME OF DECEASED (Type or Print) a. (First) Willie James	b. (Middle) Ball	c. (Last) Ball	4. DATE OF DEATH (Month) (Day) (Year) June 22, 1956
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5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) -	8. DATE OF BIRTH June 21, 1956	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days 8 35
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri	12. CITIZENSHIP OF WHAT COUNTRY? -
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13a. FATHER'S NAME Willie James Ball	13b. MOTHER'S MAIDEN NAME Marie Cody	14. NAME OF HUSBAND/OR WIFE -
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -	16. SOCIAL SECURITY NO. -	17. INFORMANT'S SIGNATURE OR NAME Marie Ball	ADDRESS above
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature separation of normally implanted placenta.		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) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 7-1-56			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) 7610
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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?
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22. I hereby certify that I attended the deceased from **June 21, 1956**, to **June 22, 1956**, that I last saw the deceased alive on **June 22, 1956**; and that death occurred at **6:35 Am.**, from the causes and on the date stated above.

23a. SIGNATURE J. Ballen m.d.	(Degree or title) D	23b. ADDRESS 6305. Kingshighway	23c. DATE SIGNED 6-23-56
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 7-31-56	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. JUL 18 1956	REGISTRAR'S SIGNATURE Charles Smith McRowland-Skel	25. FUNERAL DIRECTOR'S SIGNATURE 4404 Manchester	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

Licensed Embalmer No.....

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 embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.

If this body is not embalmed, fact should be so stated above.