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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-009487
STATE FILE NUMBER

FILED MAR 17 1958

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 272

SPRINGFIELD, MISSOURI

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|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY GREENE | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY GREENE | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN SPRINGFIELD | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Johns Hosp. | Length of stay in 1b | d. STREET ADDRESS (If outside, give location) 2018 N. Main | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First VIRGINIA Middle E. Last BALL | | | 4. DATE OF DEATH Month March Day 8 Year 1958 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 29 June 1888 | 9. AGE (In years last birthday) 69 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (City and state or country) Kentucky | 12. CITIZEN OF WHAT COUNTRY? USA | | |

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| 13a. FATHER'S NAME Russell | 13b. MOTHER'S MAIDEN NAME Matting | 14. NAME OF HUSBAND OR WIFE Frank Ball |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No | 16. SOCIAL SECURITY NO. UNKNOWN | 17. INFORMANT Hospital Records | Address |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion | | INTERVAL BETWEEN ONSET AND DEATH 2 hours |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Arterio-sclerosis | NOT KNOWN |
| | DUE TO (c) | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | |

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|--|--|--|-------------------------|-------|
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION Springfield, Missouri | COUNTY Greene | STATE |
|--|--|--|-------------------------|-------|

21. I attended the deceased from **3-7-58** to **3-8-58** and last saw her ^{her} _{him} alive on **3-7-58**
Death occurred at **8:30** P m on the date stated above; and to the best of my knowledge, from the causes stated.

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|--------------------------------------|----------------------------------|--|------------------------------------|
| 22a. SIGNATURE <i>W. Klingner</i> | (Degree or title) M.D. | 22b. ADDRESS Spgfd. Med. Bldg. Springfield, Missouri | 22c. DATE SIGNED 3-10-58 |
|--------------------------------------|----------------------------------|--|------------------------------------|

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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 3-11-58 | 23c. NAME OF CEMETERY OR CREMATORY Greenlaw | 23d. LOCATION (City, town, or county) (State) Springfield, Mo. |
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| 24. FUNERAL DIRECTOR <i>J. W. Klingner & Co.</i> | ADDRESS SPRINGFIELD MO. | 25. DATE RECD. BY LOCAL REG. 3-14-58 | 26. REGISTRAR'S SIGNATURE <i>Effie G. Melton</i> |
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(Licensed Embalmer's Statement on Reverse Side)

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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

SPRINGFIELD, MISSOURI

APR 27 1959

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 *Max Rhode*

Licensed Embalmer No. *407*
P. O. Address *Spring*

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.