

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-030016
STATE FILE NUMBER

FILED AUG 25 1958 Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 196

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>W</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Charles Mo.</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Weldon Mo.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Charles Nursing Home 4 months</u> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>1520 Valle An.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <u>Elizabeth Ballinger</u>			4. DATE OF DEATH Month Day Year <u>Aug. 10, 1958.</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Aug 17, 1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <u>74</u> Months <u>11</u> Day <u>24</u> Hours <u></u> Min. <u></u>
11. BIRTH PLACE (City, State and country) <u>Patton Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Abraham Hahn</u>		13b. MOTHER'S MAIDEN NAME <u>Amanda Bell</u>	14. NAME OF HUSBAND OR WIFE <u>Garfield Ballinger</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>none</u>	17. INFORMANT Address <u>William Skaggs 1520 Valle An. Weldon Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>Undet.</u> <u>Undet.</u>
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.) <u>4500</u>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>April 1958</u> to <u>Aug. 10, 1958</u> and last saw her alive on <u>Aug. 10, 1958</u> Death occurred at <u>2:30 p.m.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Dr. M. G. Foster M.D.</u>		22b. ADDRESS <u>St. Charles, Mo.</u>	22c. DATE SIGNED <u>Aug. 12, 1958</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, county) (State)
<u>Burial</u>	<u>Aug. 13, 1958</u>	<u>Mt. Lebanon Cem.</u>	<u>St. Charles Red Rd. Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Buell-Campbell Mortuary 5165 Delmar</u>		25. DATE RECD. BY LOCAL REG. <u>Aug 12-58</u>	26. REGISTRAR'S SIGNATURE <u>Mareecea Wilson</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Local, foreign, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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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 *Laurence O. Gehrke*.....

Licensed Embalmer No. *4974*

P. O. Address *St. Louis, Mo.*

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.