

XC 20715931
SL 17295

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-041247
STATE: FILE NUMBER
REGISTRAR'S NO. 11008

DEC 1 1958 Registration District No. 318 Primary Registration District No. 1003

300
1-57
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Madison	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N Grand St Louis Mo.	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Vets Admin Hospital	d. STREET ADDRESS (If outside, give location) 1825 Grand
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Vets Admin Hospital		Length of stay in lb 131 Days	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First George Middle E Last Ballard	4. DATE OF DEATH Month Nov Day 15 Year 1958
--	---

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/10/91	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
-----------------------	----------------------------------	---	-------------------------------------	--	--------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Jerseyville, Ill.	12. CITIZEN OF WHAT COUNTRY? USA
---	-----------------------------------	--	--

13a. FATHER'S NAME James D. Ballard	13b. MOTHER'S MAIDEN NAME Susan Steckel	14. NAME OF HUSBAND OR WIFE
---	---	-----------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If Yes, give year or dates of service) Yes	16. SOCIAL SECURITY NO. 333031015	17. INFORMANT Address VA Hosp Records 915 N Grand St Louis, Mo
--	---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC COMA		INTERVAL BETWEEN ONSET AND DEATH 6-8 HOURS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) LAENNECS CIRRHOSIS	2-3 YEARS
	DUE TO (c) 581.1	
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 checked="" type="checkbox"/> NO <input type="checkbox"/>

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.	

20d. INJURY OCCURRED WHILE AT <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 COUNTY STATE
---	--	---

21. I attended the deceased from **7/16/58** to **11/15/58** and last saw him alive on **11/15/58**
Death occurred at **3:20 PM** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Jack W. Hudson</i> M.D.	22b. ADDRESS VAH, St. Louis, Missouri	22c. DATE SIGNED 11-16-58
--	---	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11/16/58	23c. NAME OF CEMETERY OR CREMATORY Granite City, Ill	23d. LOCATION (City, town, or county) (State) Granite City, Ill
---	------------------------------	--	---

24. FUNERAL DIRECTOR ADDRESS Edward Fendler 5611 South Grand Blvd.	25. DATE RECD. BY LOCAL REG. NOV 17 '58	26. REGISTRAR'S SIGNATURE <i>Earl Smith MD</i> mbs
--	---	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Harley R. Jaeller Jr*
Licensed Embalmer No. *4950*
P. O. Address *St. Louis*

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.