

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010681

STATE FILE NUMBER

2 3148

Health,
Welfare
Public
Service

FILED APR 10 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

300
1-57

95
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 4128 Grove Street	
Length of stay in 1b Lifetime		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last RICHARD JAMES BALLARD			4. DATE OF DEATH Month Day Year MARCH 28, 1959		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 20, 1926	9. AGE (In years last birthday) 32	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter	10b. KIND OF BUSINESS OR INDUSTRY Jones Painting CO.	11. BIRTHPLACE (City and state or country) St. Louis, MO.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Charles Ballard	13b. MOTHER'S MAIDEN NAME Ruby Tinsley	14. NAME OF HUSBAND OR WIFE Never married
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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) NO	16. SOCIAL SECURITY NO. 490-22-8591	17. INFORMANT Harlan Ballard	Address 4128 Grove Street
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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) PULMONARY CONGESTION, POST-OPERATIVE		INTERVAL BETWEEN ONSET AND DEATH 4 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CONGENITAL TOTAL ANOMALOUS PULMONARY VENOUS RETURN AND INTRA-ATRIAL SEPTAL DEFECT / DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ANURIA DUE TO ACUTE TUBULAR NECROSIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2

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.) 754.7
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	

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 COUNTY STATE
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21. I attended the deceased from FEB. 3, 1959 to MARCH 28, 1959 and last saw her alive on MARCH 28, 1959
Death occurred at 6:45 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) C. C. Vermillion, M. D.	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 3/28/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Mar. 30, 1959	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County MO.
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24. FUNERAL DIRECTOR SUEDEMEYER & SON'S 3934 N. 20th Street	25. DATE RECD. BY LOCAL REG. MAR 30 '59	26. REGISTRAR'S SIGNATURE Earl Smith, M. D.
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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

17-00000 2014/10/10

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 *Herbert J. Lau Jr.*

Licensed Embalmer No. *4800*

P. O. Address *Kirkwood 22, 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.