

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011940

STATE FILE NUMBER

Registration District No. 322 Primary Registration District No. 3071 Registrar's No. 12

1. PLACE OF DEATH a. COUNTY <u>SALINE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY <u>SALINE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SLATER</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>SLATER</u> ^{97%} Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MAIN ST</u>		Length of stay in 1b <u>4 MDS.</u>	d. STREET ADDRESS (If outside, give location) <u>MAIN STREET</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>RUSSELL MARION BALLOWE SR.</u>			4. DATE OF DEATH Month Day Year <u>MAR 16, 1959</u>		
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 3 1997</u>	9. AGE (In years last birthday) <u>61</u>	10. UNDER 1 YEAR Months Days	11. 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) <u>LABORER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	11. BIRTHPLACE (City and state or country) <u>SALINE COUNTY, MO.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
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13a. FATHER'S NAME <u>ROBERT BALLOWE</u>	13b. MOTHER'S MAIDEN NAME <u>CORA LEE HILL</u>	14. NAME OF HUSBAND OR WIFE <u>EDNA COON BALLOWE</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and date of service) <u>YES WW*1</u>	16. SOCIAL SECURITY NO. <u>494-16-1432</u>	17. INFORMANT <u>RUSSELL M. BALLOWE JR.</u>	Address <u>SLATER MO.</u>
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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) <u>Tardive cyanosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Aneurysm</u>		
DUE TO (c) <u>Asthma</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>241X</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.)
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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
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21. I attended the deceased from <u>June 1957</u> to <u>March 14, 1959</u> and last saw ^{him} alive on <u>March 16, 1959</u> Death occurred at <u>9:50</u> <u>P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. <u>Embalmer</u> (Degree or title)	22b. ADDRESS <u>239 West Parker, Slater, Mo.</u>	22c. DATE SIGNED <u>3/17/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>MAR 19 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GOOD HOPE</u>	23d. LOCATION (City, town, or county) (State) <u>SALINE COUNTY, MO.</u>
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24. FUNERAL DIRECTOR <u>W.J. Daines Jr. Slater, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>3/21 '59</u>	26. REGISTRAR'S SIGNATURE <u>Mo. E. C. Metz</u>
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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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Walter J. ...*
Licensed Embalmer No. *4557*
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.