

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 28 1959

'59 0 4 3 7 7 3

STATE FILE NUMBER

ENDED

Registration District No. 7 Primary Registration District No. _____ Registrar's No. 53

1. PLACE OF DEATH a. COUNTY <u>DeKalb</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Gentry</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mayville</u>		Length of stay in lb <u>5 days</u>		c. CITY OR TOWN <u>King City</u>		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>Sunset Nurs. Home</u>				d. STREET ADDRESS (If outside, give location) <u>213 W. Vermont</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Christopher</u> Last <u>Ball</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/5/71</u>	9. AGE (last birthday) <u>88</u>	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Section Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>C.B. & Q. RR.</u>		11. BIRTHPLACE (City and state or country) <u>Buchanan Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>William G. Ball</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy (Unknown)</u>		14. NAME OF HUSBAND OR WIFE <u>Martha Jane Ball</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>Forrest Ball Lincoln, Neb.</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>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ a.m. _____ p.m.		Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <u>Dec. 2, 1959</u> to <u>Dec. 7, 1959</u> and last saw him alive on <u>Dec. 7, 1959</u> Death occurred at <u>7:40 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Shirley Taylor M.D.</u>				22b. ADDRESS <u>Mayville MO</u>		22c. DATE SIGNED <u>12/9/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Dec. 7, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>King City Cem.</u>		23d. LOCATION (City, town, or county) <u>King City Mo.</u>	
24. FUNERAL DIRECTOR <u>Harold E. Keasel</u>		ADDRESS <u>King City, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>12-17-59</u>		26. REGISTRAR'S SIGNATURE <u>Rasmussen</u>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS OCT 7 1960

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

Harold E. Woodruff

Licensed Embalmer No.

4609

P. O. Address

King City

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.