

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-018172

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 784

FILED MAY 28 1962

1. PLACE OF DEATH a. COUNTY <b>BUTLER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>HOWELL</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>POPLAR BLUFF</b>		Length of stay in 1b <b>10 DAYS</b>	c. CITY OR TOWN <b>MOUNTAIN VIEW,</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VA. HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>GEN. DEL.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>ALVIN LEO BALL</b>			4. DATE OF DEATH Month Day Year <b>MAY 14, 1962</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-14-99</b>
9. AGE (last birthday) <b>63</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>UNKNOWN</b>	11. BIRTHPLACE (City and state or country) <b>MOUNTAIN VIEW, MO</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>WILLIAM J. BALL</b>	
13b. MOTHER'S MAIDEN NAME <b>SARAH BRYLES</b>		14. NAME OF HUSBAND OR WIFE <b>NONE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW2</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	17. INFORMANT Address <b>VA. HOSPITAL RECORDS, POPLAR BLUFF, MO</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <b>UREMIA</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 Months</b>	
DUE TO (b) <b>SENILE NEPHROSCLEROSIS</b>		IN HOSPITAL <b>10 DAYS</b>	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>PNEUMONITIS AND PANSINUSITIS</b>			
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 Month, Day, Year s.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
21. I attended the deceased from <b>MAY 4, 1962</b> to <b>MAY 14, 1962</b> Death occurred at <b>8:17PM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Robert S. Cohen</b> <b>ROBERT S. COHEN, M.D., Chief Med. Svc.</b>		22b. ADDRESS <b>VA. HOSPITAL POPLAR BLUFF, MO.</b>	22c. DATE SIGNED <b>5-16-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>5-15-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cem.</b>	23d. LOCATION (City, town, or county) <b>Mt. View, Mo.</b>
24. FUNERAL DIRECTOR <b>Frank-Cotrell Poplar Bluff, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>5/22/1962</b>	26. REGISTRAR'S SIGNATURE <b>Thelma Graham</b>	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300 Rev. 4/59

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3460

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USE BLACK INK OR TYPEWRITER RIBBON

**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 Scott Cottrill, Student Embalmer No. 658

working under my personal supervision.

Student Scott Cottrill  
Signature of Student Embalmer

Signed Edgar W. Lyfson

Licensed Embalmer No. 3394

P. O. Address Poplar Bluff 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.