DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
SEP 0 AUG 11 1939

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23718

Registration District No. 791 1003

Primary Registration District No.

Registrar's No. 5991

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: De Paul Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution One day (Specify whether
In this community 36 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis 8
(If outside city or town limits, write "RURAL")

(d) Street No. 8830 Partridge Ave
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Howard E. Ballman 455

3. (b) If veteran, name war World war Navy

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ann C. Ballman

6. (c) Age of husband or wife if alive 38 years

7. Birth date of deceased Sept 10 1902
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
36	9	25	hr. min.

9. Birthplace St. Louis, Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Manager 0

11. Industry or business Baden Show 0

FATHER
12. Name Robert H Ballman
13. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Ollie Gertrude Elliott
15. Birthplace , Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Anna C. Ballman
(b) Address 8830 Partridge Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-8-39
(Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove Mausoleum

18. (a) Signature of funeral director Math Hermann & Son
(b) Address 2161 Fair Ave.

19. (a) JUL 7 1939 (Date received local registrar) (b) J. F. Biedeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 5
year 1939 hour 3:30 AM minute M.

21. I hereby certify that I attended the deceased from June 29th, 1939, to July 5, 1939
that I last saw him alive on July 5th, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Gangrenous Choce cystitis No stones

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations Gangrene of the Gall Bladder no stones
Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature A J Gettinger (M. D. or other)
Address 2745 N Grand Bl Date signed 7/6/39

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed. Leonard Hampton

Licensed Embalmer No. 2967

P. O. Address 2161 C. Fair

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.