S. No. —11-10 ... 5-1 ...

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 16 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24469

Registration District No. 1 Primary Registration District No. 1 Registrar's No. 182

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1
2
2

1. PLACE OF DEATH:

(a) County Adair

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

(c) Name of hospital or institution: Laughlin Hospital (If not in hospital or institution, write street number or location) 1

(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community 12 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lewis

(c) City or town Rural (If outside city or town limits write "RURAL") 0

(d) Street No. (If rural, give location)

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

3. (a) PRINT FULL NAME Wanna LaVon Bally 400

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Ray S. Bally

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

7. Birth date of deceased Feb. 4, 1914 (Month) (Day) (Year)

8. AGE: Years 26 Months 5 Days 30 If less than one day hr. min.

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

10. Usual occupation Farmwife 0

11. Industry or business Agriculture 0

FATHER
12. Name Robert W. Marks
13. Birthplace Monticello (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Rose Atha Jenkins
15. Birthplace Monticello (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Ray S. Bally

(b) Address Monticello, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 4, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Monticello Cemetery

18. (a) Signature of funeral director Davis Funeral Home

(b) Address Kirksville, Mo.

19. (a) Aug. 3/40 (Date received local registrar) (b) Spencer L. Freeman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 2 year 1940 hour 4 minute 30 A.M.

21. I hereby certify that I attended the deceased from July 20, 1940, to Aug 2, 1940 that I last saw her alive on Aug 2, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Puerperal Eclampsia

Due to Toxemia of Pregnancy.

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

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? 3 (e) Means of injury

23. Signature John H Denby DO (M. D. or other) 3

Address Kirksville Date signed Aug 3

(Licensed Embalmer's Statement on Reverse Side)

146

RECEIVED
District Health Officer No. 10
District File Number 8-40-1653
Date Filed AUG 15 1940

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 Harold K. Weigal

Licensed Embalmer No. 4076

P. O. Address Kirkwood, 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 this body is not embalmed, above space should be left blank.

S. No. 2B
I—2-21-40
I X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24469

Registration District No. 1 Primary Registration District No. 1 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Adair

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

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

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits write "RURAL")

(d) Street No. (If rural, give location)

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

3. (a) PRINT FULL NAME Wanna LaVon Bally

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 26 Months 5 Days 30 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

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

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 9/9/1940 (Date received local registrar) (b) Spencer L. Freeman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 2 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Puerperal Eclampsia

Due to Toxemia of pregnancy

Due to Cause of toxemia of pregnancy not known: there are several theories.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Delivery of 7 month live baby one hour before death -

Of autopsy 146

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 John H. Denby (M. D. or other)

Address Kirksville Date signed