

FILED AUG 9 1940
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

24906

State File No. _____

Registration District No. 198

Primary Registration District No. 3011

Registrar's No. 109

1. PLACE OF DEATH:

(a) County Clay
(b) City or town Excelsior Springs 3
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Ball Health School
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 months
(Specify whether _____)
In this community _____
years, months or days 1/17

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County unshown
(c) City or town Mound City
(If outside city or town limits, write "RURAL")
(d) Street No. unshown
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME ARTHUR J. BALL

3. (b) If veteran, Civil War 3. (c) Social Security No. _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Rachel Jane (c) Age of husband or wife if alive _____ years
Ma Nancy C. Maas

7. Birth date of deceased May 15 1846
(Month) (Day) (Year)

8. AGE:			If less than one day
Years	Months	Days	
<u>94</u>	<u>2</u>	<u>2</u>	hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business Banker

12. Name Elisha Ball

13. Birthplace unshown West Virginia
(City, town, or county) (State or foreign country)

14. Maiden name Jane Walker

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

16. (a) Informant Mary E. Plain

(b) Address Mapleton, Kansas

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

(c) Place: burial or cremation Mound City, Kansas

18. (a) Signature of funeral director Herbert H. Hays

(b) Address Excelsior Springs
19. (a) 7-18-40 (b) Geo. R. McCracken
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 17 day July
year 1940 hour 5 minute 08 P.M.

21. I hereby certify that I attended the deceased from Jan 1940, to 7-17 1940
that I last saw him alive on 7-17 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Duration 3 yrs.

Due to age

Due to 93°C

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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? _____

While at work? _____ (Specify kind of place) (e) Means of injury _____

23. Signature W. D. Ostricher (M. D. or other) D.O.

Address EXCELSIOR OSTEOPATHIC SANITARIUM, INC. Date signed 7/17/40

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

4
2
1

MOTHER FATHER

RECEIVED
District Health Officer No. 8,
District File Number 8-5-40
Date Filed

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 Scott W. Hockensmit

Licensed Embalmer No. 3597

P. O. Address Episcopal Spr

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.