

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.

FILED DEC 14 1940

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

38812  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Hessburg Registration District No. 347  
 (b) Township Bechtelton Primary Registration District No. 5489A  
 (c) City Bechtelton (d) Street No. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.  
 2. PRINT FULL NAME Mrs. Bevie Simmons  
 (a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr 9th 1874  
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
66 7 21 \_\_\_\_\_  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. housekeeper  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) 15-9 June 11. Total time (years) spent in this occupation \_\_\_\_\_  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO.  
 FATHER 13. NAME James W. Ballard  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky  
 MOTHER 15. MAIDEN NAME Louisa J. Ballard  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marion Co. Mo.  
 17. INFORMANT Miss Lillian Ballard  
 (ADDRESS) Brownington Mo. R. 2  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Good Hope DATE Dec. 1 1940  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Ms. C. A. Rickett  
Brownington, Mo.  
 20. FILED 12/10 19 40 Dr. J. R. Henshaw Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 30 19 40  
 22. I HEREBY CERTIFY, That I attended deceased from June 15 19 40 to Nov 30 19 40  
 I last saw her alive on about May 15 19 40 Death is said to have occurred on the date stated above, at 9:55 A. M.  
 The principal cause of death and related causes of importance were as follows:  
Carcinoma of gall-bladder Date of onset late Jan 1940  
46  
 Other contributory causes of importance: Diabetes mellitus  
 Name of operation None Date of \_\_\_\_\_  
 What test confirmed diagnosis? Clinical Was there an autopsy? No  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? None Date of injury \_\_\_\_\_, 19 \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_  
 Manner of injury None  
 Nature of injury \_\_\_\_\_  
 24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_ (Signed) B. Hughes M. D.  
Clinton, Mo. (Address)

RECEIVED

District Health Officer No. 7,

District File Number 12-40-1784

Date Filed 12-12-40

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**