DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 4 1941

Registration District No. 73

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 10019

Primary Registration District No. 3006

Registrar's No. 70

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

**1. PLACE OF DEATH:**
(a) County: Boone
(b) City or town: Columbia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Ellis Fischel State Cancer Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days (Specify whether years, months or days)
In this community 0

**2. USUAL RESIDENCE OF DECEASED:**
(a) State: Missouri (b) County: Montgomery 70
(c) City or town: Montgomery City 1 0
(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: HOMER BALL
3. (b) If veteran, name war: ____
3. (c) Social Security No.: ____
4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: Widower
6. (b) Name of husband or wife: not Known
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: Dec. (Month) 26 (Day), 1854 (Year)

8. AGE: Years 86 | Months 2 | Days 19 | If less than one day ____ hr. ____ min.

9. Birthplace: Georgetown (City, town, or county) Ohio (State or foreign country)
10. Usual occupation: Farmer
11. Industry or business: ____
FATHER
12. Name: Not Known
13. Birthplace: (City, town, or county) ? (State or foreign country)
MOTHER
14. Maiden name: Not Known
15. Birthplace: (City, town, or county) ? (State or foreign country)
16. (a) Informant: County Clerk Gentry
(b) Address: Montgomery City, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mar. 17, 1941 (Month) (Day) (Year)
(c) Place: burial or cremation: Gregory Cem. Danville Mo
18. (a) Signature of funeral director: J. M. Marland
(b) Address: Montgomery City Mo
19. (a) 3/17/41 (Date received local registrar) (b) Allie Selby (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month March day 15 year 1941 hour 6 minute 45 P. M.
21. I hereby certify that I attended the deceased from March 11, 1941 to March 15, 1941; that I last saw him alive on March 15, 1941 and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|---|
| Pneumonia | 5 days |
| Terminal Bronchial | |
| Due to Carcinoma of lip and | ? |
| face | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |

Major findings:
Of operations ____
Of autopsy ____

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: Louis P. Hartz (M. D. or other) M.D.
Address: Ellis Fischel Hosp. Date signed 4/15/41

(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.....

Licensed Embalmer No.....

P. O. Address.....

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

**If this body is not embalmed, fact should be so stated above.**

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State File No. 10019

Registration District No. 73 Primary Registration District No. 3006 Registrar's No.

**1. PLACE OF DEATH:**

(a) County Boone

(b) City or town Columbia
(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
In this community years, months or days)

**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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Homer Ball

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

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 | Months | Days | If less than one day |
|---|---|---|---|---|
| | 86 | 2 | 19 | 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) (Date received local registrar) (b) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Mar day 18
year 1941 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.

| | Duration |
|---|---|
| Immediate cause of death Pneumonia Terminal Bronchial ~~Carcinoma of lip and~~ | |
| Due to ~~(cause)~~ 45a | |
| Due to | |
| Other conditions 1) Carcinoma of lower lip (Include pregnancy within 3 months of death) 2) Carcinoma of nose | primary |

Major findings:
Of operations
Of autopsy

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 (M. D. or other)
Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

SUPPLEMENTARY

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

S-10009 1941

## 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 compl the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**