No. 2
-8-43
-17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. F 20468

FILED JUL 15 1944

Registration District No. 1884 Primary Registration District No. 1002 Registrar's No. 2741

1. PLACE OF DEATH:

(a) County Jackson,

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

(c) Name of hospital or institution:
2843 Troost,
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson, 48

(c) City or town Kansas City, 38
(If outside city or town limits, write "RURAL")

(d) Street No. 2843 Troost,
(If rural, give location)

(e) Citizen of foreign country? no. (Yes or No)
If yes, name country x 0

3. (a) PRINT FULL NAME Miss Sarah Ballew

3. (b) If veteran, name war no.

3. (c) Social Security No. no.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife x

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

7. Birth date of deceased May (Month) 6 (Day) 1853 (Year)

8. AGE: Years 91 Months 1 Days 29 25 If less than one day hr. min.

9. Birthplace (City, town, or county) Iowa 0 (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 Mrs. Mary Stafford,

(b) Address 3937 St. John, Kansas City, Mo.

17. (a) removal (Burial, cremation, or removal) (b) Date thereof 6-30-44 (Month) (Day) (Year)

(c) Place: burial or cremation Carrollton, Missouri

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 7-1-44 (Date received local registrar) (b) R. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30th year 1944 hour 10:15 minute a. M.

21. I hereby certify that I attended the deceased from June 1, 1940 to June 30, 1940 that I last saw h. alive on June 25, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: apoplexy	1 wk
Due to: General Arterio Sclerosis	1 yr
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 0

23. Signature Frederick A. Balsiger (M. D. or other) MD

Address 31 Tarsyl Bldg Date signed 7/1/44 K.C. Mo.

(Licensed Embalmer's Statement on Reverse Side)

Dr. Frederick Baldwin, Argyle Bldg.

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 John H. Hurley

Licensed Embalmer No. 4050

P. O. Address Kansas City 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, fact should be so stated above.

No. 2B
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. July

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2741

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: 2843 Troost.
(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) unknown

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 Sarah Ballew

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex

5. Color or race

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

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 hr. min.

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

10. Usual occupation none

11. Industry or business

FATHER 12. Name Thomas Ballew

13. Birthplace (City, town, or country) (State or foreign country) Va.

MOTHER 14. Maiden name Mary Downey

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

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) 7-1-44 (Date received local registrar) (b) M. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30 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 — Duration

Due to

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 (M. D. or other)

Address Date signed

20468