No. 2
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7-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED SEP 16 1947
Registration District No. 147

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 31078
Registrar's No. 3737

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

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: 803 Oak St Room 105
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community ..... unknown.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 803 Oak St 8
(If rural, give location) 0
(e) Citizen of foreign country? unknown (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME Grover Cleveland Ball
3. (b) If veteran, name war no
3. (c) Social Security No. none.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased 1897 (Month) (Day) (Year)

8. AGE: Years 50 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Do not know (City, town, or county) 9 (State or foreign country)
10. Usual occupation Do not know
11. Industry or business
FATHER
12. Name
13. Birthplace (City, town, or county) 9 (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) 9 (State or foreign country)
16. (a) Informant Coroner office
(b) Address K C Mo
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept 2. 47 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Calvary K C K
18. (a) Signature of funeral director Passant Mo Bros
(b) Address K C Mo
19. (a) 9-2-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 29
year 1947 hour 3 10 minute P M.
21. I hereby certify that I attended the deceased from Coroner, 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 Coronary insufficiency	
Due to Arteriosclerosis	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 956	
Of autopsy no History & Inspection	

PHYSICIAN
Underline the cause of 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: 3
23. Signature [signature] (M. D. or other) Coroner
Address 1424 Prospect Mdy Date signed 8-29-47

Jefferson City Printing Co.
(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. J. S. Walton

Licensed Embalmer No. 2744

P. O. Address. K. C. 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.