

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

13142

XC-3992 058  
REG. #522 SL 515

State File No. ....

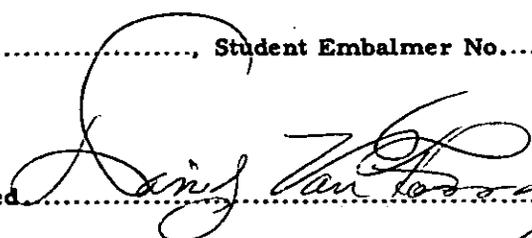
BIRTH NO. FILED APR 26 1954 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 33641

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN 915 N. Grand, St. Louis, Mo.)		c. LENGTH OF STAY (in this place) 6 days	c. CITY OR TOWN ST. LOUIS
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSP.		e. STREET ADDRESS 1809 LYNCH	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or Print) LUKE		a. (First)	b. (Middle)
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY	8. DATE OF BIRTH 7/1/19
13a. FATHER'S NAME LUKE BALCH SR.		13b. MOTHER'S MAIDEN NAME MAGGIE COLE	9. AGE (In years last birthday) 34
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WW-2		16. SOCIAL SECURITY NO. 496-30-1208	4. DATE OF DEATH (Month) (Day) (Year) APRIL 14, 1954
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		11. BIRTHPLACE (City and State or Foreign Country) / AMAGON, ARKANSAS	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		12. CITIZEN OF WHAT COUNTRY? USA	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MASSIVE ATELECTASIS OF LEFT LUNG		14. NAME OF HUSBAND OR WIFE GLAUDUS BALCH	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) BRONCHIAL PNEUMONIA DUE TO (c) COLLOID CYST OF 3RD VENTRICLE OF BRAIN		17. INFORMANT'S SIGNATURE OR NAME ADDRESS VA HOSPITAL RECORDS, ST. LOUIS, MO.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 223X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) VA		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4/8, 1954, to 4/14, 1954, and that death occurred at 10:10 P.M., from the causes and on the date stated above.			
23a. SIGNATURE J. A. Kaminskas (Degree or title) M.D.		23b. ADDRESS VAH, ST. LOUIS, MO.	
23c. DATE SIGNED 4/15/54			
24a. BURIAL CREMA- TION REMOVAL (Specify) Removal Train 4-15-54		24b. NAME OF CEMETERY OR CREMATORY Balch Cemetery	
24c. LOCATION (City, town, or county) (State) Newport, Ark.			
DATE REC'D BY LOCAL REG. APR 15 1954		REGISTRAR'S SIGNATURE J. Carl Smith MD 6322 S. Grand Blvd.	

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was  
by me, or by ..... Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  


Licensed Embalmer No.....

P. O. Address 63421.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING to comply with the above constitutes grounds for revocation of license).**  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.