

FILED JUL 22 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23205

State File No.

BIRTH NO. _____ REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 3026 Registrar's No. 281

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> <u>NEW JERSEY</u> COUNTY <u>CANON</u>	
b. CITY (If outside corporate limits, write RURAL, and give township) OR TOWN <u>Independence</u>	c. LENGTH OF STAY (in this place) <u>9 days</u>	c. CITY OR TOWN <u>Hale</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Sanitarium</u>		e. STREET ADDRESS (If rural, give location) <u>none</u> <u>0170</u>	
3. NAME OF DECEASED a. (First) <u>William</u>		b. (Middle) <u>E.</u>	c. (Last) <u>Ballenger</u>
4. DATE OF DEATH <u>July 16, 1954</u>		5. SEX <u>male</u>	
6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	
8. DATE OF BIRTH <u>Sept. 19, 1879</u>		9. AGE (In years last birthday) <u>74</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gospel</u>	
11. BIRTHPLACE (City and State or Foreign Country) <u>Stockton, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Elijah Ballenger</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Ballenger</u>	
14. NAME OF HUSBAND OR WIFE <u>Cora M. Ballenger</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Roy L. Ballenger,</u> ADDRESS <u>Kansas City, Kans.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</u> <u>C Hemiplegia & Coma</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		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 <u>July 6, 1954</u> , to <u>July 16, 1954</u> , that I last saw the deceased alive on <u>July 15, 1954</u> , and that death occurred at <u>1:25A</u> m., from the causes and on the date stated above.	
23a. SIGNATURE <u>R. Allen M.D.</u> (Degree or title)		23b. ADDRESS <u>Independence, Mo.</u>	
23c. DATE SIGNED <u>7/16/54</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>7/19/54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Washington Cem.</u>	
24d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>		DATE REC'D BY LOCAL REG. <u>7-19-54</u>	
REGISTRAR'S SIGNATURE <u>[Signature]</u>		FUNERAL DIRECTOR'S SIGNATURE <u>J. C. Garson</u> ADDRESS <u>Independence, Mo.</u>	

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

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Tom D Marklan*

Licensed Embalmer No. *450*

P. O. Address *Indep.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.