

Health,
Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

57 01 17 68

FILED JUN 11 1957

STATE FILE NUMBER

Registration District No. 174 Primary Registration District No. 5644 Registrar's No. 59

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lexington Twns</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Odessa</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Goodloe Nurseing home</u>			Length of stay in lb <u>3 Mo</u>	d. STREET ADDRESS (If outside, give location) <u>South end</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Columbus</u> Middle <u>Marshall</u> Last <u>Ball</u>			4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1957</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 6, 1878</u>		9. AGE (In years last birthday) <u>78</u> IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>agriculture</u>	11. BIRTHPLACE (City and state or country) <u>Cole Camp, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Ball</u>				14. MOTHER'S MAIDEN NAME <u>Safrone Dillon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>492-14-7209</u>		17. INFORMANT Address <u>Denny Ball, Odessa, Mo.</u>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio Sclerotic Heart disease</u> DUE TO (c) <u>H200</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs -</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>March 57</u> to <u>Apr 25-57</u> and last saw her alive on <u>Apr 20-57</u> . Death occurred at <u>6 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>J. B. Koppenshine, M.D.</u> (Degree or title)				22b. ADDRESS <u>Higginsville, Mo</u>		22c. DATE SIGNED <u>May 2-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Apr. 27, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Odessa Cemetery</u>		23d. LOCATION (City, town, or county) (Side) <u>Odessa, Mo.</u>		
24. FUNERAL DIRECTOR <u>Husman-Sparks</u> ADDRESS <u>Odessa, MO.</u>			25. DATE RECD. BY LOCAL REG. <u>5-17-57</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

(Licensed Embalmer's Statement on Reverse Side)

8:00 PM

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 James T. [Signature]
Licensed Embalmer No. 752

P. O. Address Ocean

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.