

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-019455

STATE FILE NUMBER

Registrator's No. 5487

FILED JUN 11 1958

Registration District No.

318

Primary Registration District No.

1003

S. 300
-57

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, give TOWNSHIP only) OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST. LOUIS Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ALEXIAN BROS. HOSP.		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 239 2745 ACCOMAC Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Louis Middle F Last BALLMANN			4. DATE OF DEATH Month MAY Day 24 Year 1958
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 16 1870
9. AGE (In years last birthday) 87		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CLERK		10b. KIND OF BUSINESS OR INDUSTRY RICE-STIX	11. BIRTHPLACE (City and state or country) KRAKOW MO.
12. CITIZEN OF WHAT COUNTRY? U-S-A		13a. FATHER'S NAME BERNARD BALLMANN	
13b. MOTHER'S MAIDEN NAME ANGELA ROLF		14. NAME OF HUSBAND OR WIFE FRANCES BALLMANN (DECD)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -	17. INFORMANT AGNES MOLL 2745 ACCOMAC ST Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral sclerosis DUE TO (b) Cerebral apoplexy DUE TO (c) Chronic myocardiitis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 4 months 4 months 6 months
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.) 422-2	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <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 12-24-57 to 5-24-58 and last saw him alive on 5-24-58 Death occurred at 5-24-58 9:15 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE John D. Smith (Degree or title)		22b. ADDRESS 0 3739 Beavers	22c. DATE SIGNED 5-26-58
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE MAY 28 1958	23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY	23d. LOCATION (City, town, or county) (State) ST LOUIS MO
24. FUNERAL DIRECTOR Thomas H. Hutto 2906 Gravois ADDRESS		25. DATE RECD. BY LOCAL REG. MAY 26 58	26. REGISTRAR'S SIGNATURE Chas. Smith

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 C. Will*

Licensed Embalmer No. *43471*

P. O. Address *2906 Shaw*

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.