

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-028396

042

1000

755

STATE FILE NUMBER

AMENDED

FILED AUG 7 1961

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH a. COUNTY Buchanan			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Buchanan			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 28yrs	c. CITY OR TOWN St. Joseph,		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Ayr Lawn Addition		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Norman Charles Ballard			4. DATE OF DEATH Month Day Year July 24, 1961			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Aug 11, 1933	9. AGE (last birthday) 28	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) St. Disabled		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) St. Joseph, Mo	12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Delmar Ballard		13b. MOTHER'S MAIDEN NAME Lillian Walker		14. NAME OF HUSBAND OR WIFE Louise Ballard		
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. none	17. INFORMANT Address Lillian Ballard, St. Joseph, Mo			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Azotemia DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH About 4 days About 8 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Secondary hypochromic anemia Cardiac enlargement with bilateral hydrothorax, diabetes mellitus					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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.	Month, Day, Year					
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 1954 to 7/24/61 and last saw him alive on July 24, 1961 Death occurred at 2:15 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE E Handler (Degree or title)		22b. ADDRESS 311 Physician's & Surg. Bldg. St. Joseph, Missouri		DATE SIGNED 7-26-61		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7/27/61	23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	23d. LOCATION (City, town, or county) St. Joseph, Mo	(State)		
24. FUNERAL DIRECTOR John E. Krupp	ADDRESS St. Joseph, Mo	25. DATE RECD. BY LOCAL REG. July 31, 1961	26. REGISTRAR'S SIGNATURE Mrs. Clark Stodell			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

E. Handler, M.D.

ITEM NO. SHOULD READ

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,

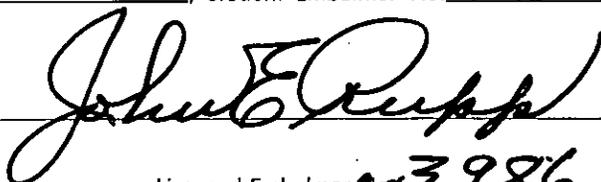
~~_____~~ _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____



Licensed Embalmer No. 3986

P. O. Address St Joseph

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.