

No. 2  
M-5-43  
5-17-39  
I X38671

**FILED** OCT 27 1946

Registration District No. \_\_\_\_\_ Primary Registration District No. **198 5700**

**1. PLACE OF DEATH:**

(a) County **Livingston**

(b) City or town **Grand River Twp**

(c) Name of hospital or institution: **None, other Hospital**  
(If not in hospital or institution, write street number & location)

(d) Length of stay: In hospital or institution **10 days**  
(Specify whether)

In this community **all of life**  
years, months or days

**3. (a) PRINT FULL NAME** **Mary, E. Ballew**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow**

6. (b) Name of husband or wife **John O Ballew** 6. (c) Age of husband or wife if alive **Deceased** years

7. Birth date of deceased **Sept. 29. 1870**  
(Month) (Day) (Year)

**8. AGE:** Years **75** Months **11** Days **27** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

**9. Birthplace** **Stagers Mo.**  
(City, town, or county) (State or foreign country)

**10. Usual occupation** **Housewife**

**11. Industry or business**

**12. Name** **Jacob Engelman**

**13. Birthplace** **Mo.**  
(City, town, or county) (State or foreign country)

**14. Maiden name** **Susan Selzer**

**15. Birthplace** **Madison Mo.**  
(City, town, or county) (State or foreign country)

**16. (a) Informant** **Stella Ballew**

**(b) Address** **Hale Mo.**

**17. (a)** **Burial** **Hale Cemetery** **(b) Date thereof** **9-28-1946**  
(Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation**

**18. (a) Signature of funeral director** **Stella Ballew**

**(b) Address** **Hale Mo.**

**19. (a)** **Sept 28-1946** **(b) Mrs Cecil Bloss**  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Mo.** (b) County **Livingston**

(c) City or town **Rural**  
(If outside city or town limits, write "RURAL")

(d) Street No. **Grand River Twp**  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month **Sept** day **26**  
year **1946** hour **3** minute **45** A.M.

**21. I hereby certify that I attended the deceased from** **Sept 19, 1946 to Sept 26, 1946**  
that I last saw her alive on **Sept 25, 1946**  
and that death occurred on the date and hour stated above.

Immediate cause of death: **embolism of heart** **Sudden**  
Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

**PHYSICIAN**

Major findings: **AYA**  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Underline the cause to which death should be charged statistically.

**22. If death was due to external causes, fill in the following:**

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury **2**

**23. Signature** **Cherith** (M. D. or other) **2**

Address **Cherith Mo.** Date signed **9-26-46**

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

MOTHER FATHER

OCT 7 8 1946

DISTRICT HEALTH OFFICE  
Cameron, Mo.

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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed *Frank E Slater*

Licensed Embalmer No. *937*

P. O. Address *Hale Mo*

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 this body is not embalmed, fact should be so stated above.