S. No. 2
M—8-43
. 5-17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 14 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14391

Registration District No. 297 — Primary Registration District No. 6021 — Registrar's No. 6

1. PLACE OF DEATH

(a) County Ray
(b) City or town Rural Thrd
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1 Hosp Inc
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ray 89
(c) City or town RURAL 0
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Daniel Bascom Ballew

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Susie Ballew

6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased March (Month) 28 (Day) 1868 (Year)

8. AGE: Years 77 Months 0 Days 21 If less than one day hr. min.

9. Birthplace Ray Co, Mo (City, town, or county) 0 (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER
12. Name Geo. W. Ballew
13. Birthplace Kentucky (City, town, or county) 0 (State or foreign country)

MOTHER
14. Maiden name Sarah Bell
15. Birthplace unknown (City, town, or county) 0 (State or foreign country)

16. (a) Informant Mrs Susie Ballew
(b) Address Conway, Mo

17. (a) (Burial, cremation, or removal) C (b) Date thereof APR 21 45 (Month) (Day) (Year)
(c) Place: burial or cremation Conway Mo

18. (a) Signature of funeral director C. H. Reed
(b) Address Conway Mo

19. (a) 4/25/1945 (Date received local registrar) (b) Mrs Thos W Shepard (Registrar's signature)

1280

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19th
year 1945 hour Two minute 30 P.M.

21. I hereby certify that I attended the deceased from April 17th, 1945, to April 19, 1945; that I last saw her alive on April 19, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	4/17/45 to 4/19/45
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) Hemoplegia	4yrs

PHYSICIAN

Major findings:
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
(c) 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? (Specify type of place)
While at work (e) Means of injury

23. Signature John R Grant (M. D.)
Address Conway Mo Date signed 4/20/45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 5/12/45

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 [redacted]; Registered Apprentice No. ,

working under my personal supervision.

Signed C. A. Reed

Licensed Embalmer No. 2194

P. O. Address Concrete Wn.

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.