

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

12201

State File No. \_\_\_\_\_

Registration District No. 796

Primary Registration District No. 6039

Registrar's No. 58

1. PLACE OF DEATH:

(a) County Saline Mo

(b) City or town Marshall Twp  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community 83 years  
years, months or days

3. (a) PRINT FULL NAME W. Boyd Ingram

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 Widowed

6. (b) Name of husband or wife Mollie Reid Ingram 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased Nov 18 1857  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>83</u>	<u>4</u>	<u>0</u>	hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name James S. Ingram

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

14. Maiden name Mary Jane Cochran

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

16. (a) Informant Leta Ingram

(b) Address Marshall Mo

17. (a) Burial (b) Date thereof Feb 20 - 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ingram, Cemetery

18. (a) Signature of funeral director Chas. R. Rife

(b) Address Marshall Mo.

19. (a) 3-20-41 (b) W. A. Kent  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline Mo

(c) City or town Marshall Twp  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 18  
year 1941 hour 5 minute 30 P. M.

21. I hereby certify that I attended the deceased from March 13 1941 to March 16 1941  
that I last saw him alive on March 16 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia Duration 3 days

Due to Influenza, heart 10 days

Due to old fracture left hip 1 yr

Other conditions Myocardial Ch. ?

(Include pregnancy within 3 months of death)

PHYSICIAN \_\_\_\_\_

Major findings: \_\_\_\_\_

Of operations None

Of autopsy None

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) NO

(b) Date of occurrence None

(c) Where did injury occur? None  
(City or town) (County) (State)

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

23. Signature W. E. Edwards (Specify type of place) \_\_\_\_\_  
While at work? ✓ (e) Means of injury 2 A

23. Signature W. A. Kent (M. D. or other) 11/3/41

Address Marshall Mo Date signed 3/19/41

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

No. 2  
-11-10-39  
5-17-39  
I X21492

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 7-11-74

**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 *James H. Lewis*

Licensed Embalmer No. *1171*

P. O. Address *Marshall M*

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, above space should be left blank.