WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 9499

PLACE OF DEATH

County: Johnson

Township: Chilhowee — Registration District No. 429 — File No. ~~9498~~

or Village: ~~Magnolia Mo~~ — Primary Registration District No. 5581 — Registered No. 3

or City: _____ (NO. _____, _____ St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME James Mike Ingram

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: Caucasian

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: March (Month) 27 (Day), 1870 (Year)

AGE: 47 yrs. 11 mos. 27 ds. — If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer): Auto Repairs

BIRTHPLACE (City or town, State or foreign country): Chillicothe, Mo.

PARENTS
NAME OF FATHER: James Turner Ingram
BIRTHPLACE OF FATHER (City or town, State or foreign country): Kentucky
MAIDEN NAME OF MOTHER: Sarah Austin
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Kentucky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S R Sweeney

(ADDRESS) Chilhowee Mo

Filed Nov 27, 1918 — W L Martin, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Nov (Month) 24 (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 10, 1918, to Nov 24, 1918, that I last saw him alive on Nov 24, 1918, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH*, was as follows:

Chronic Cronfous Nephritis

Dont Know

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY): 120

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) R L Bills, M. D.

(Address) Magnolia Mo

13-24 1918

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Fairfield Mo

DATE OF BURIAL: 3/25 1918

UNDERTAKER: S. R. Sweeney

ADDRESS: Chilhowee

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... , *1*.....
(Month) (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

..... , 191..... , ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

..... , *191*.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....,
that I last saw h.....alive on ....., 191.....,
and that death occurred, on the date stated above, at .....m.
The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs. .....mos. .....ds.

Contributory .....
(SECONDARY)
.....(Duration).....yrs. .....mos. .....ds.

(Signed) ..... M. D.

..... , 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191.....
UNDERTAKER	**ADDRESS**