

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.

AUG 9 1935

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

Do not use this space.

1. PLACE OF DEATH **St. Mary's Infirmary**

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City **St. Louis** (No.....)

791
1008
1536 Papin

File No.....

Registered No.....

24593

5988

St. Ward)

2. FULL NAME **Elliott Ingram**

(a) Residence, No. **2108 Eugenia** St. **2** Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs. **2** mos. **21** ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Colored

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **April 19, 1935**

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

2

21

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.....

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.....

10. Date deceased last worked at this occupation (month and year).....

11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY)

St. Louis Missouri

MOTHER FATHER

13. NAME **Harris Ingram**

14. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY)

15. MAIDEN NAME **Alice Tabrom**

16. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY)

17. INFORMANT **Alice Ingram**
(ADDRESS) **2108 Eugenia**

18. BURIAL, CREMATION, OR REMOVAL

PLACE **Anatomical Board** DATE **7-12 35**

19. UNDERTAKER **St. Louis Univ. Medical School**
(ADDRESS) **St. Louis, Mo.**

20. FILED

JUL 13 1935

J. T. Bredeck
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **July 10, 1935**

22. I HEREBY CERTIFY, That I attended deceased from **June 18, 35**, to **July 10, 35**

I last saw him alive on **July 10, 1935**. Death is said

to have occurred on the date stated above, at **9:30A.**

The principal cause of death and related causes of importance were as follows:

Miliary Tuberculosis Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy? **Yes**

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?.....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? **No**

If so, specify.....

(Signed) **James E. Jackson**, M. D.

(Address) **1536 - Papin - St.**

