

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

37510  
 Do not use this space.

1. PLACE OF DEATH *Bright*

(a) County *Bright* Registration District No. *906*

(b) Township *Easton* Primary Registration District No. *6221*

(c) City *Mansfield* (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_

(e) Length of residence in city or town where death occurred \_\_\_\_\_ yrs. mos. ds. (f) How long in U.S., if of foreign birth? \_\_\_\_\_ yrs. mos. ds.

2. PRINT FULL NAME *Henry Ingrison*

(a) Residence, No. *Bright Co. Mansfield* (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widow*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<i>47</i>	<i>9</i>	<i>19</i>	

OCCUPATION

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

9. Industry or business in which work was done, as 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) *Wisconsin*

FATHER

13. NAME *L. J. Snell*

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

MOTHER

15. MAIDEN NAME *T. M. Hoar*

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

17. INFORMANT *Archie Ingrison* (ADDRESS) *Mansfield Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Family Cemetery* DATE *Sept 27 1939*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Russell Barber* *1100 N. 2nd St. Mo.*

20. FILED *Oct. 13 1939* *Ella Claxton* Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept 24 1939*

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at *5:30 PM*.

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

Date of onset \_\_\_\_\_

Other contributory causes of importance: *None*

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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? \_\_\_\_\_ If so, specify \_\_\_\_\_

(Signed) *H. P. Murrell* (Address) *Hartsville Mo.*

MARGIN RESERVED FOR BINDING

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

V. S. NO. 2. 50M-9-19-39 I X18605

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.

RECEIVED

District Health Officer No. 6,

District File Number 1139-2298

Date Filed NOV 9 1939

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 Russell Barber

Licensed Embalmer No. 3848

P. O. Address Mt. Grove, 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, above space should be left blank.