

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 7822

Registration District No. 209

Primary Registration District No. 6291

Registrar's No.

1. PLACE OF DEATH:
(a) County Pack
(b) City or town Rondo - Jefferson
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location) W
(d) Length of stay: In hospital or institution. (Specify whether

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Pack
(c) City or town Rural
(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.?

In this community _____ years, months or days
3. (a) PRINT FULL NAME Benj. F. Ingram
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 9
year 1940 hour 10 minute 00 P. M.

4. Sex male 5. Color or race wht 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Sybil Ingram 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug 7, 1866
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Feb 7, 1940 to Feb 9, 1940
that I last saw him alive on Feb 7, 1940
and that death occurred on the date and hour stated above
Immediate cause of death Cerebral hemorrhage Duration _____

8. AGE: Years 73 Months 6 Days 22 If less than one day hr. min.

Due to arteriosclerosis
Due to _____

9. Birthplace Rondo Mo
(City, town, or county) (State or foreign country)
10. Usual occupation Farmer

Other conditions (Include pregnancy within 3 months of death) g.w.

MOTHER FATHER
11. Industry or business _____
12. Name Jack Ingram
13. Birthplace Greene Co Mo
(City, town, or county) (State or foreign country)
14. Maiden name Betty McGarrett
15. Birthplace Tennessee
(City, town, or county) (State or foreign country)

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Sybil Ingram
(b) Address Wilmington
17. (a) Burial (b) Date thereof Feb 11, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Rondo Cemetery
18. (a) Signature of funeral director J.R. Luster
(b) Address Wheatland Mo
19. (a) 2-15-1940 (b) Veda McDeracken
(Date received local registrar) (Registrar's signature)

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? 629
(Specify type of place) (e) Means of injury _____
23. Signature W.W. Gouverman (M. D.)
Address Humansville, Mo Date signed Feb 13, 1940

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Rev. 5-17-39

RECEIVED
State Health Officer No. 7,
Public Health Center 3-40-507
Date Filed 3-15-49

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 *J.P. L...*
Licensed Embalmer No. *2962*
P. O. Address *Wheatland*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 7822

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 709

Primary Registration District No. 0938

Registrar's No.

1. PLACE OF DEATH:

(a) County DeWitt
(b) City or town Jefferson
(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..... (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Polk
(c) City or town rural
(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.?..... years.

3. (a) PRINT FULL NAME

Ben J Ingram

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years
7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years 73 Months 6 Days 22 If less than one day..... min.

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

10. Usual occupation.....
11. Industry or business.....
12. Name.....
13. Birthplace..... (City, town, or county) (State or foreign country)
14. Maiden name.....
15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant..... (b) Address.....
17. (a)..... (b) Date thereof..... (Month) (Day) (Year)
(Burial, cremation, or removal) (Specify type of place)
(c) Place: burial or cremation.....

18. (a) Signature of funeral director J.P. Guckey
(b) Address Wheatland Mo
19. (a) 9-15-1940 (b) Veda M. Beck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 9
year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....
that I last saw him..... alive on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Due to.....
Due to.....
Other conditions..... (Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....

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?

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature H.H. Bowersman (M. D. or other)
Address Hannasville Mo

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTAL COPY

