

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

29480
Do not use this space.

FILED SEP 25 1940

1. PLACE OF DEATH
 (a) County Ripley Registration District No. 2
 (b) ~~Township~~ St. Patrick Primary Registration District No. 750
 or St. Paul Street No. 5986
 (c) Aug - Current River (If death occurred in Hospital or Institution, write its name instead of street and number)
 (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 Alex Ingram
 (a) Residence, No. Ripley Co. Mo. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 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) July 9-1910

7. AGE YEARS 30 MONTHS 1 DAYS 1 If LESS than 1 day, hrs. or min.

OCCUPATION

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

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) Ripley Co Mo

MOTHER

13. NAME Gas. Ingram

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

15. MAIDEN NAME Mendakice

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

17. INFORMANT (ADDRESS) Albert Ingram

18. BURIAL, CREMATION, OR REMOVAL PLACE New Lebanon Cem DATE 8/11 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. H. Gammill
Stanton, Mo

20. FILED 8-11-40 C. B. Johnson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8/10 1940

22. I HEREBY CERTIFY, That I attended deceased from 8/8 1940 to 8/10 1940
 I last saw him alive on 8/8 1940. Death is said to have occurred on the date stated above, at 10p m.
 The principal cause of death and related causes of importance were as follows:
Pneumonia
Arthritis
 Other contributory causes of importance:
 Name of operation no Date of no
 What test confirmed diagnosis? no Was there an autopsy? no

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 no

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify
 (Signed) J. Carreus M. D.
 (Address) 674 Pitman, Ark.

109W

109W

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.....
Licensed Embalmer No.....
P. O. Address.....

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. **29480**
Registrar's No. **1693**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **750**

Primary Registration District No. **5986**

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

1. PLACE OF DEATH:

(a) County **Repley**
(b) City or town **Current River**
(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 _____
years, months or days)

3. (a) PRINT FULL NAME **Alec 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 **8**

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 **30** Months **1** Days **1** If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **8** day **10**
year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw h. _____ alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia** Duration _____
Bronchial
Due to _____
Due to _____ **1070**
Other conditions **arthritis**
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

PHYSICIAN

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) _____
(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 **J. J. Carrene** (M. D. or other) _____
Pitman
Address _____ Date signed **10/29/40**

