

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **36068**

Registration District No. **690**

Primary Registration District No. **5918**

Registrar's No. **10**

1. PLACE OF DEATH:

(a) County **Pike**
(b) City or town **Hartford Township (Rural)**
(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 **20**
(Specify whether
In this community **35 yrs**
years, months or days)

3. (a) PRINT FULL NAME **Ida May Ankrom**

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

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Charkly Ankrom** 6. (c) Age of husband or wife if alive **59** years

7. Birth date of deceased **May 4th. 1884**
(Month) (Day) (Year)

8. AGE: Years **56** Months **5** Days **18** If less than one day
hr. _____ min. _____

9. Birthplace **Montgomery County, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife (At Home)**

11. Industry or business _____

12. Name **James Madison McKinsey**
13. Birthplace **Lincoln County, Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **North Carolina**
15. Birthplace **North Carolina**
(City, town, or county) (State or foreign country)

16. (a) Informant **Charley Ankrom**
(b) Address **Middletown, Missouri**

17. (a) **Burial** (b) Date thereof **10/24/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **West Prairie Cem.**

18. (a) Signature of funeral director **James E. Wells**
(b) Address **Middletown, Missouri**

19. (a) **10-24-40** (b) **nurse [signature]**
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **mo** (b) County **Pike**
(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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **22**
year **1940** hour **6** minute **7** M.

21. I hereby certify that I attended the deceased from **March 23**, 1940, to **Oct 22**, 1940;
that I last saw her alive on **Oct 12**, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of ascending colon with metastasis to liver.**

Due to **liver.**

Due to _____

Other conditions **4/10**
(Include pregnancy within 3 months of death)

Major findings: **None**
Of operations _____

Of autopsy **None**

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? **837**

(e) Means of injury _____ (Specify type of place)

23. Signature **Walter Barrymore** (M. D. or other) **1**
Address **Cawling Green, Mo** Date signed **10/24/40**

RECEIVED

District Health Officer No. 10

District File Number 11-40-2047

Date Filed NOV 8 1940

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.....

By me, Registered Apprentice No.
working under my personal supervision.

Signed.....

Licensed Embalmer No. 588

P. O. Address Phillips Miss

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.