

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

27687

State File No. _____

Station District No. 4

Primary Registration District No. 6232

Registrar's No. 35

1. PLACE OF DEATH:

(a) County AUDRAIN
(b) City or town RURAL CULVRE TWS.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1/10 MI SOUTH OF VANDALIA
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 70 YRS.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County AUDRAIN
(c) City or town RURAL CULVRE TWS.
(If outside city or town limits, write "RURAL")
(d) Street No. 10 Miles South VANDALIA
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 23rd
year 41 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from Aug 13th 41
Aug 23 1941 to Aug 23 1941
that I last saw him alive on Aug 23 1941
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Intestinal
Neuritis

Duration

Due to _____
Due to _____

Other conditions Control of Property
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy 131B

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? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature A. Hino (M. D. or other) _____
Address middleton mo Date signed 8/24/41

3. (a) PRINT FULL NAME CHARLES BOYD INGRAM

3. (b) If veteran, name war _____ 3. (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife JULIA INGRAM 6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased AUGUST 30 1860
(Month) (Day) (Year)

8. AGE: Years 70 Months 11 Days 24 If less than one day hr. _____ min. _____

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

10. Usual occupation FARMER

11. Industry or business _____

12. Name STEPHEN INGRAM

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

14. Maiden name MARY CREWS

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

16. (a) Informant Mrs. Charley Ingram

(b) Address Vandalia, Missouri

17. (a) BURIAL (b) Date thereof Aug 25 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MOUNT OLIVET CEMETERY

18. (a) Signature of funeral director W. J. Waters

(b) Address Vandalia Mo

19. (a) Aug 25 41 (b) R. Lee Alford
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

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

4
20

4
10
0

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 9-41-1698

Date Filed SEP 18 1941

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 Thos B. Waters

Licensed Embalmer No. 24169

P. O. Address Vandalia 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27687
Registrar's No. 38

Registration District No. 4

Primary Registration District No. 6232

1. PLACE OF DEATH:

(a) County Andrew
(b) City or town Rural Centre Twp
(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)

Length of stay: In hospital or institution _____
(Specify whether

in this community _____
years, months or days)

3. (a) PRINT FULL NAME Charles B. 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 MARRIED

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 _____ Months _____ Days _____ 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)

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Oct 31 (b) R. Seeger (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 24 Year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

Duration _____

Due to _____

Due to _____

Other conditions _____ (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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

