

FILED NOV 14 1941

Registration District No. 773

Primary Registration District No. 6018A

Registrar's No. 1421

1. PLACE OF DEATH:

(a) County St. Francois  
(b) City or town St. Francois  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: State Hospital No. 4  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 9 months, 7 days  
(Specify whether years, months or days)  
In this community 9 months, 7 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Madison  
(c) City or town Higdon  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 8th  
year 1941 hour 2 minute 40 A.M.

21. I hereby certify that I attended the deceased from 10-5-41  
to 10-8-41  
that I last saw him in alive on 10-7-41  
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic Heart Disease  
Due to Arteriosclerosis, generalized & marked  
Due to \_\_\_\_\_

Other conditions Diabetic Nephrosis, Simple Retinitis  
(Include pregnancy within 3 months of death)

Major findings: Of operations NO  
Of autopsy NO  
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 NO  
(c) Where did injury occur? NO  
(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 0  
23. Signature C. C. Cull (M.D. or other) M.D.  
Address Farmington, Mo. Date signed 10-10-41

3. (a) PRINT FULL NAME STEPHEN PERRY INGRAM  
3. (b) If veteran, name war Unknown  
3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Widower  
6. (b) Name of husband or wife Unknown  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: August 23 1866  
(Month) (Day) (Year)

8. AGE: Years 75 Months 1 Days 15  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Laborer

MOTHER FATHER { 11. Industry or business \_\_\_\_\_  
12. Name Unknown  
13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant State Hospital No. 4 Records  
(b) Address Farmington, Missouri

17. (a) Burial (b) Date thereof 10-9-41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation State Hospital Cemetery

18. (a) Signature of funeral director Richardson Funeral Home  
(b) Address Farmington, Missouri

19. (a) Oct 8-41 (b) B. J. Robinson  
(Date received local registrar) (Registrar's signature)

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

7400

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.....

*Body not Embalmed.*....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... *Chas. Richardson*.....

Licensed Embalmer No. *3167*.....

P. O. Address..... *Hamington 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.