

Registration District No. **318**

Primary Registration District No. **2001**

State File No. _____

Registrar's No. **926**

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **Springfield, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1501 N. NATIONAL BOULEVARD
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Greene**
(c) City or town **Springfield**
(If outside city or town limits, write "RURAL")
(d) Street No. **1501 N. National Boulevard**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **26th**
year **1941** hour **3** minute **55 A.M.**
21. I hereby certify that I attended the deceased from **Feb. 1941**
19____ to **Nov 19** 19____
that I last saw her alive on **Nov-19-** 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis** Duration _____

Due to **Osteoarthritis**
Due to **Senility**

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

23. Signature **D. F. Youell** (M.D. or other) _____
Address **234 1/2 E. Commercial St.** Date signed **11/26/41**

Physician _____
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME **CHRISTINA INGALLS.**

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

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **JOSEPH E. INGALLS** 6. (c) Age of husband or wife if alive **90** years

7. Birth date of deceased **May 19 1858**
(Month) (Day) (Year)

8. AGE: Years **83** Months **6** Days **7** If less than one day _____ hr. _____ min.

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

10. Usual occupation **House W. ify**

11. Industry or business **In home**

12. Name **Evans C. Evans**

13. Birthplace **Unknown Norway** (City, town or county) (State or foreign country)

14. Maiden name **Unknown**

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

16. (a) Informant **E. C. Ingalls**
(b) Address **1501 N. National Springfield, Mo.**

17. (a) **burial** (b) Date of coffin **Nov. 28-1941**
(Month) (Day) (Year)
(c) Place: burial or cremation **Oak Grove Cem.**

18. (a) Signature of funeral director **J. W. Klingner**
(b) Address **Springfield, Mo.**

19. (a) **11-27-41** (b) **W. E. Handley M.D.**
(Date received local registrar) (Registrar's signature)

984

(Licensed Embalmer's Statement on Reverse Side) **Springfield, Mo.**

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

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 *Roy A. Leamon*
Licensed Embalmer No. *1763*
P. O. Address *Springfield 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.