

FILED OCT 20 1942

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
General Hospital No. 20
(If not in hospital or institution, write street number or location)
9-12-42-9-20-42
(d) Length of stay: In hospital or institution 17 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1517 Garfield
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country. 0

3. (a) PRINT FULL NAME JOHN INGRAM

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife. unk. 6. (c) Age of husband or wife if alive 30 years
7. Birth date of deceased. September 1870
(Month) (Day) (Year)

8. AGE: Years 71 Months 11 Days 20 If less than one day hr. min.

9. Birthplace. Kentucky / None
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business

MOTHER FATHER { 12. Name Green Ingram
13. Birthplace unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Aminda
15. Birthplace unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk
(b) Address General Hospital No. 2

17. (a) Burial (b) Date thereof 10-8-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation burial

18. (a) Signature of funeral director Wm A. Bohney

(b) Address City mortician

19. (a) 10-8-42 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September, Day 20, year 1942 hour 9 minute 40 a. M.

21. I hereby certify that I attended the deceased from September 12 42 to September 20 42 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Sclerosis Duration Arterio

Due to 77
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Same as above
Of autopsy Same as above

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 0

23. Signature J. C. Deane (M. D. or other) 0
Address Ten. Hosp. #2-600622 Date signed 10-8-42

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

48
83

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, fact should be so stated above.