

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **7242**

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

1. PLACE OF DEATH:

(a) County.....
 (b) City or town..... **St. Louis, Missouri**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Homer G. Phillips Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **17 days**
 In this community **20 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... **Missouri** (b) County..... **000**
 (c) City or town..... **St. Louis,** (If outside city or town limits, write "RURAL") **17**
 (d) Street No. **2114 Delmar** (If rural, give location) **219**
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country..... **no** **0**

3. (a) PRINT FULL NAME **James Ingram**

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

4. Sex **Male** 5. Color or race **col** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **none** 6. (c) Age of husband or wife if alive **none** years

7. Birth date of deceased **April 7 1887**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	56	4	2 hr. min.

9. Birthplace **Ashelet N.C.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Jobber**

11. Industry or business **Self**

12. Name **Unknown**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Dorinda Watts**

(b) Address **1420 Mc Carland ave.**

17. (a) **Removal** (b) Date thereof **8-11-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **E. St. Louis**

18. (a) Signature of funeral director **D. J. Mack**

(b) Address **3849 Page Blvd**

19. (a) **AUG 11 1943** (b) **J. F. Bredack**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **9,**
year **1943** hour **5** minute **30 A.M.**

21. I hereby certify that I attended the deceased from **July 23,** 19**43,** to **August 9,** 19**43;**
that I last saw him alive on **August 9,** 19**43;**
and that death occurred on the date and hour stated above.

Immediate cause of death..... **Cancer of Bladder - Urinary** Unk.
Duration

Due to.....
Due to..... **52**

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

While at work?..... (Specify type of place) (c) Means of injury.....

23. Signature **A. K. Fleet** (M. D. or other) **0**
Address **2601 Whittier** Date signed **8/9/43**

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.....

3847 Page Blvd....., Registered Apprentice No.....
working under my personal supervision.

Signed C. J. Nash.....

Licensed Embalmer No. 2432.....

P.O. Address 3847 Page Blvd.....

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.