

U. S. No. 2
FORM-5-43
Rev. 5-17-39
1 X36871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4390

State File No. _____

FILED MAR 3 1945 318

Registration District No. _____

Primary Registration District No. _____

1003

Registrar's No. _____

1493

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(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 2 Hrs. 55 Mins
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2110 Clark Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME David Ingram Jr.

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

4. Sex Male 2 5. Color or race Negro 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased. 2 1 45
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 2 hr. 55 min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name David Ingram Sr.

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

14. Maiden name Gladys Myers

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

16. (a) Informant Annie Marie Phillips
(b) Address 2601 N. Whittier Street

17. (a) Burial (b) Date thereof FEB 15 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director V. B. Hudson

(b) Address City Health Dept

19. (a) FEB 14 1945 (b) J. F. Bruce
(Date received local registrar's certificate) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 1
year 45 hour 6 minute 55 a.m.
21. I hereby certify that I attended the deceased from 2 - 1
19 45 to 2 - 1 19 45
that I last saw him alive on 2 - 1 19 45
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Prematurity
Due to Unknown
Due to Unknown

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? _____

(Specify type of place) _____
While at work? _____ (g) Means of injury _____
23. Signature William S. Smith (M. D. or other) _____
Address 2601 N. Whittier St. Date signed 2-9-45

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.....

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.