

**FILED** SEP 6 1945

Registration District No. **65**

Primary Registration District No. **5250**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County **CHARITON**

(b) City or town **BRUNSWICK "RURAL"**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **CHARITON**

(c) City or town **BRUNSWICK "RURAL"**  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **IDA MAY GINGELL**

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JULY** day **31** year **1945** hour **2** minutes **20** P.M.

4. Sex **FEMALE** 5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

21. I hereby certify that I attended the deceased from **July 31 - 45** 1945 to **July 31** 1945 that I last saw her alive on **July 31** 1945 and that death occurred on the date and hour stated above.

7. Birth date of deceased **SEPTEMBER 14** 1871  
(Month) (Day) (Year)

Immediate cause of death **Carcinoma Colon**

8. AGE:	Years	Months	Days	If less than one day
	<b>73</b>	<b>10</b>	<b>17</b>	hr. _____ min. _____

Due to \_\_\_\_\_

Due to \_\_\_\_\_

9. Birthplace **BRUNSWICK MISSOURI**  
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

10. Usual occupation **AT HOME**

Major findings: **462**  
(1) Of operations **Carcinoma Colon**

11. Industry or business **HOUSEWORT**

Of autopsy \_\_\_\_\_

12. Name **LEVI TRILEY**

PHYSICIAN \_\_\_\_\_ Underline the cause to which death should be charged statistically.

13. Birthplace **CHARITON Co. MISSOURI**  
(City, town, or county) (State or foreign country)

14. Maiden name **JENNIE GLENN**

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

16. (a) Informant **WM. GINGELL**

(b) Address **BRUNSWICK MO**

17. (a) **BURIAL** (b) Date thereof **8-2-1945**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **PRairie Chapel Church BRUNSWICK MO**

18. (a) Signature of funeral director **J. W. Gering**

(b) Address **BRUNSWICK MO**

19. (a) **Aug 2 45** (b) **A. J. Oriesz**  
(Date received local registrar) (Registrar's signature)

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)

23. Signature **J. L. Tapp** (MFD. or other) \_\_\_\_\_

Address **Brumswick** Date signed **8/31/45**

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

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed.....

*9-2-48*

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..... *L. W. Maerial*

Licensed Embalmer No. *823*

P. O. Address *Brunswick N*

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.