

FILED SEP 21 1945

Registration District No. _____

Primary Registration District No. 2000

Registrar's No. 200

1. PLACE OF DEATH:

(a) County Adair
 (b) City or town Kirksville
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Nursing Home annex
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 months
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME MRS. JOELLA INGRAHAM

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced ✓

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

7. Birth date of deceased: Jan 10 1860
 (Month) (Day) (Year)

8. AGE: 84 Years 8 Months 13 Days If less than one day hr. _____ min. _____

9. Birthplace Howard Co. Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name Wm. Wingate

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

14. Maiden name Amanda Preston

15. Birthplace Adair Co Mo
 (City, town, or county) (State or foreign country)

16. (a) Informant W. G. Ingraham

(b) Address Kirksville Mo

17. (a) Burial (b) Date thereof 8-25-45
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Hill Cem.

18. (a) Signature of funeral director Summers

(b) Address Kirksville Mo

19. (a) 9-5-45 (b) Mrs. J. Wagoner
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Adair
 (c) City or town Kirksville
 (If outside city or town limits, write "RURAL")
 (d) Street No. 405 So. High St
 (If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 23
 year 1945 hour 8 minute 30 A.M.

21. I hereby certify that I attended the deceased from June 16 1945 to Aug 23 1945
 that I last saw h. cr. alive on Aug 23 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death: myocardial failure Duration days

Due to _____
 Due to _____

Other conditions: Broken hip
 (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) 124 ✓

(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 _____

23. Signature Geo. W. Harrison (M. D. or other) MO

Address C. N. H. Kirksville Date signed Aug 23 1945

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

5-43
5-17-39
X36671

RECEIVED

District Health Officer No. 10

District File Number 9-45-1459

Date Filed SEP 19 1945

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 W. C. Summers

Licensed Embalmer No. 2159

P. O. Address Evansville, Ind.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. act
Registrar's No. 200

Registration District No. 1

Primary Registration District No. 3000

1. PLACE OF DEATH:
(b) County Adair
(b) City or town Kirkville
(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 _____ (b) County _____
(c) City or town _____ (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 Joella Ingraham
(b) If veteran, name war _____ (c) Social Security No. 3

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Year 1945 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec 10 (Month) 10 (Day) _____ (Year)

Duration _____
Due to _____
Due to _____

8. AGE: Years 84 Months _____ Days _____ If less than one day _____ hr. _____ min.
9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Operations _____
Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

10. Usual occupation _____
11. Industry or business _____
12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____
(b) Address _____
19. (a) _____ (b) _____ (Registrar's signature)
(Date received local registrar)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident
(b) Date of occurrence 5-11-45
(c) Where did injury occur? Kirkville Adair MO (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? slw Hospital
While at work? no (Specify type of place) (e) Means of injury fall
23. Signature Geo. H. Lawson (Doctor or other) MD
Address Kirkville, MO Date signed 9-24-45

SUPPLEMENTARY

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

MOTHER FATHER

30004