

16141 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED JUN 12 1946

STANDARD CERTIFICATE OF DEATH

State File No. **17260**

Registration District No. **174**

Primary Registration District No. **51670**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lincoln
 (b) City or town Osney
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution XX
(Specify whether years, months or days)
 In this community all her life

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Lincoln
 (c) City or town Osney MO
(If outside city or town limits, write "RURAL")
 (d) Street No. X
(If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country XX

3. (a) PRINT FULL NAME Lillian A. Ingram

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased July 1871
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>7</u>	<u>12</u>	hr. _____ min. _____

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

10. Usual occupation House Keeper

11. Industry or business _____

12. Name Marcus T. Ingrouse
 13. Birthplace Warren Co. Mo.
 14. Maiden name Miss Annie Sperry
 15. Birthplace Lincoln Co. Mo.

16. (a) Informant Mrs. Robt. Saunders
 (b) Address Osney, Mo.

17. (a) Bural (b) Date thereof 2-22-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Osney, Mo.

18. (a) Signature of funeral director W. P. Dammund

(b) Address Siles, Mo.

19. (a) _____ (b) Mrs. Emma B. Riddle
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 20
 year 1946 hour 11 AM minute _____ M.

21. I hereby certify that I attended the deceased from Sept. 1945 to Feb. 18, 1946
 that I last saw him alive on Feb. 18, 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Nephritis
 Due to Arteriosclerosis

Due to _____
 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.
3/1/46

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 _____
 Signature R. M. Ceme (M. D. or other) _____
 Address Siles - Mo. Date signed _____

142

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 me

XX, Registered Apprentice No. XX,
working under my personal supervision.

Signed W. P. Dammund

Licensed Embalmer No. 2251

P. O. Address Sibley MD

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. June

Registration District No. 179

Primary Registration District No. 5670

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lincoln

(b) City or town Osney
(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 years, months or days)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Lillian A. Ingram

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 _____ S

6. (b) Name of husband or wife _____

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

7. Birth date of deceased _____
(Month) (Day) (Year)

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

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Mo. E. B. Pille
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1946 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 _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

Duration _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

17260