

S. No. 2
M-8-43
7-5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38906**

FILED DEC 5 1947
Registration District No. **209**

Primary Registration District No. **2042**

Registrar's No. **397**

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

1. PLACE OF DEATH

(a) County **Marion**

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

(c) Name of hospital or institution: **St Elizabeth Hosp**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **6 days** (Specify whether
In this community **3 yrs** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Pike**

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

(d) Street No. **611 mound** (If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **David L. Ingram**

3. (b) If veteran, **No** name war _____

3. (c) Social Security No. **yes**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **21**
year **1947** hour **11** minute **30 AM**

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

6. (b) Name of husband or wife **Faunne Ingram** 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased **Nov.** **8 - 1865**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Nov - 16** 19**47** to **Nov 21** 19**47**
that I last saw h **in** alive on **Nov 21** 19**47**
and that death occurred on the date and hour stated above.

8. AGE: Years **82** Months **0** Days **13** If less than one day
hr. _____ min. _____

Immediate cause of death **Valeriana**

Due to **Cardiovascular Recanal** **5**

Due to **Stroke** **1**

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

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

10. Usual occupation **Retired farmer**

11. Industry or business _____

Major findings:
Of operations _____

Of autopsy **9329**

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

MOTHER FATHER { 12. Name **Was on Ingram**

13. Birthplace **N. Carolina** (State or foreign country)

14. Maiden name **Eliza Henderson**

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

16. (a) Informant **Mrs R. C. Akers**

(b) Address **Hannibal Mo.**

22. If death was due to external causes, fill in the following:

17. (a) **Wick Creek Cem** (b) Date thereof **Nov-23-1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Wick Creek Cem.**

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

18. (a) Signature of funeral director **W. B. Ervore**

(b) Address **Bowling Green**

(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? _____

19. (a) **11-26-47** (b) **Dr E M Lucke**
(Date received local registrar) (Registrar's signature) **KFD**

While at work? _____ (Specify type of place)

(e) Means of injury **0**

23. Signature **W. B. Ervore** (M. D. or other) _____
Address **Hannibal Mo** Date signed _____

Nov 24 - 47

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 M. B. Emore

Licensed Embalmer No. 3466

P. O. Address Bohling Ave

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.