

No. 2  
12-45  
17-39  
X47070

UNITED STATES OF AMERICA  
BUREAU OF THE CENSUS  
FILED DEC 22 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40936

State File No. \_\_\_\_\_

Registration District No. 12

Primary Registration District No. 1000

Registrar's No. 1171

1. PLACE OF DEATH:  
(a) County St. Joseph  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: State Hospital # 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 32 yrs 7 mos 7 days  
(Specify whether 11 11)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3906 St. John Ave  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Vera Ingles  
3. (b) If veteran, name war No  
3. (c) Social Security No. Rel

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 12 day 17  
year 1947 hour 2 minute 22 a.m.  
21. I hereby certify that I attended the deceased from Jawist, 1947 to 12-17-1947  
that I last saw her alive on 12-11-1947  
and that death occurred on the date and hour stated above.

4. 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 Jaw 20 1882  
(Month) (Day) (Year)

Immediate cause of death Hypostatic pneumonia Duration 1 week  
Due to partial obstruction of the upper intestinal tract 6 wks  
Due to probably malignant ?

8. AGE: Years Months Days If less than one day  
65 10 22 hr. min.  
9. Birthplace Kansas City Mo  
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations 16K  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

11. Industry or business \_\_\_\_\_  
12. Name J. R. Ingles  
13. Birthplace New York  
(City, town, or county) (State or foreign country)  
14. Maiden name St. Mary, Brock  
15. Birthplace Michigan  
(City, town, or county) (State or foreign country)

16. (a) Informant Ida May Ingles  
(b) Address 3906 St. John Ave  
17. (a) Removed (b) Date thereof 12-13-47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Kansas City, Mo  
18. (a) Signature of funeral director Stoney Funeral Home  
(b) Address St. Joseph Mo  
19. (a) 12-16-47 (b) Elva Jenkins  
(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) Mode 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 [Signature] (M. D. or other) \_\_\_\_\_  
Address State Hospital # 2, St. Joseph Mo Date signed 12/17/47

---

---

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.....

Charles M. Harman, Registered Apprentice No. 450  
working under my personal supervision.

Signed.....

John Roy Stamey  
Licensed Embalmer No. 2435

P. O. Address St Joseph

**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.