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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 12 1948

Registration District No. 618

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 34288

Registrar's No. 9059

1. PLACE OF DEATH:

(a) County: None

(b) City or town: Saint Louis (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 4595 Cote Brilliante Ave. (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 15 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: None

(c) City or town: Saint Louis (If outside city or town limits, write "RURAL")

(d) Street No.: 4595 Cote Brilliante Ave. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country:

3. (a) PRINT FULL NAME: INGRUM, Matt

3. (b) If veteran, name war: None

3. (c) Social Security No.: 702-12-6551

4. Sex: Male

5. Color or race: Negro

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Glossie

6. (c) Age of husband or wife if alive: 49 years

7. Birth date of deceased: January 27th, 1897 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
51	8	19	hr. min.

9. Birthplace: Bentonia (City, town, or county) Mississippi (State or foreign country)

10. Usual occupation: Foreman

11. Industry or business: Terminal Railroad Ass'n.

MOTHER FATHER

12. Name: Cato Ingrum

13. Birthplace: Bentonia (City, town, or county) Mississippi (State or foreign country)

14. Maiden name: Henrietta Stuckey

15. Birthplace: Bentonia (City, town, or county) Mississippi (State or foreign country)

16. (a) Informant: Glossie Ingrum

(b) Address: 4595 Cote Brilliante Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/20/48 (Month) (Day) (Year)

(c) Place: burial or cremation: St. Peters Cemetery

18. (a) Signature of funeral director: Charles J. Gates

(b) Address: 4107-09 Finney Ave

19. (a) OCT 19 1948 (Date received local registrar) (b) J. B. Sander (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 16th year 1948 hour minute 6 00 p.m.

21. I hereby certify that I attended the deceased from Oct. 9th '48, 19..., to Oct. 16th, 1948, that I last saw him alive on October 16th, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cardiac Failure	1 mo.
Due to: Hypertension and	3-4 years
Chronic Hypertensive Heart	
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.

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)

While at work? (e) Means of injury:

23. Signature: Albert Kaplan (M. D. or other)

Address: University Club Bldg. Date signed 10-18-48

(Licensed Embalmer's Statement on Reverse Side)

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

John K. Cunningham, Registered Apprentice No.

working under my personal supervision.

Signed John K Cunningham

Licensed Embalmer No. 4476

P. O. Address 4107 Finney Avenue

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.