

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15409**

FILED MAY 7- 1952

REG. DIST. NO. **360**

PRIMARY REG. DIST. NO. **6225**

Registrar's No. **52**

1. PLACE OF DEATH a. COUNTY Veron		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE Mo b. COUNTY Johnson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Washington Township		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital # 3		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Holden 0510	
d. STREET ADDRESS (If rural, give location) 1			
3. NAME OF DECEASED (Type or Print) a. (First) Flissa b. (Middle) Susanna c. (Last) Ingram			4. DATE OF DEATH (Month) (Day) (Year) 4-8-1952
5. SEX F	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept 15-1873
9. AGE (In years last birthday) 78		IF UNDER 1 YEAR Months 6 Days 23	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME Thomas A. Conrad		13b. MOTHER'S MAIDEN NAME Caroline Geley	14. NAME OF HUSBAND OR WIFE Bertram L. Ingram
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Records State Hospital # 3 Nevada Mo.
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Arteriosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH 6 mos ANTECEDENT CAUSES DUE TO (b) arteriosclerosis cerebral 3 years Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senile Psychosis 4 Months	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 352x		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan 22, 1952 , to April 8, 1952 , that I last saw the deceased alive on April 7, 1952 , and that death occurred at 3:25 a.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) George Wheeler Wilson M.D.		23b. ADDRESS State Hosp # 3 Nevada Mo	23c. DATE SIGNED 4-8-1952
24a. BURIAL, CREMATION, REMOVAL (Specify) Removed	24b. DATE 4-8-52	24c. NAME OF CEMETERY OR CREMATORY Mt. Calvary	24d. LOCATION (City, town, or county) (State) Holden Mo
DATE REC'D BY LOCAL REG. 5-3-52	REGISTRAR'S SIGNATURE Anna E. Ferris 451	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Eichinger Funeral Home Nevada, Mo.	

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

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Marsh. Eisker

Licensed Embalmer No. 2656

P. O. Address Yvada, Mo -

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.