

FILED AUG 28 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

No. 300  
10-48

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 381 PRIMARY REG. DIST. NO. 45-16 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <u>SULLIVAN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>SULLIVAN</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>MILAN</u>		c. LENGTH OF STAY (In this place)	
c. CITY OR TOWN <u>MILAN</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>SIMPSON HOSPITAL</u>		e. STREET ADDRESS (If rural, give location) <u>1050</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>MONTIE</u> b. (Middle) <u>SEIGAL</u> c. (Last) <u>INGRAM</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>AUG 13 1954</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED 2</u>	8. DATE OF BIRTH <u>JUNE 15 1882</u>
9. AGE (In years last birthday) <u>72</u>		10. AGE (In years if under 1 year) Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MEAT CUTTER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) <u>INDIANNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13a. FATHER'S NAME <u>THOMAS INGRAM</u>		13b. MOTHER'S MAIDEN NAME <u>AMANDA HUDSON</u>	
14. NAME OF HUSBAND OR WIFE <u>MARY E INGRAM</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>496-10-4861</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>MARY-JANE CLEWENGER MILAN</u>	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>coronary stenosis. B. block</u> <u>liver</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>coron. calcium</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>153 X</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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) (Min.)		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 <u>12-July, 1954</u> , to <u>13-Aug, 1954</u> , that I last saw the deceased alive on <u>Aug. 13, 1954</u> , and that death occurred at <u>9:15 P.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Wm Simpson, M.D.</u>		23b. ADDRESS <u>Milans Mo</u>	
23c. DATE SIGNED <u>8-14-54</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>AUG 15, 1954</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>DAKWA CO.</u>		24d. LOCATION (City, town, or county) (State) <u>MILAN MO</u>	
DATE REC'D BY LOCAL REG. <u>8-17-1954</u>		REGISTRAR'S SIGNATURE <u>320 H. B. Harris</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Heggs Funeral Home</u>		ADDRESS <u>Milans</u>	

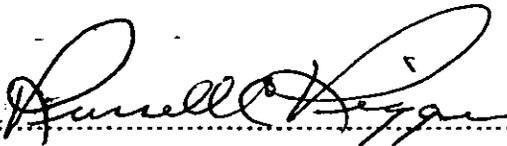
(Licensed Embalmer's Statement on Reverse Side)

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

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.....  
Signature of Student Embalmer

Signed: 

Licensed Embalmer No. 328

P. O. Address 

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.