

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8726**
1136
Registrar's No.

FILED MAR 26 1957

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>1136</u>			
1. PLACE OF DEATH a. COUNTY JACKSON				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). - a. STATE KANSAS				b. COUNTY WYANDOTTE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY			c. LENGTH OF STAY (In this place) 16 months		c. CITY OR TOWN KANSAS CITY		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Crestwood Nursing home				e. STREET ADDRESS (If rural, give location) 93 South 16th					
3. NAME OF DECEASED (Type or Print) a. (First) JAMES		b. (Middle) FRANKLIN		c. (Last) INGOLD		4. DATE OF DEATH (Month) (Day) (Year) March 9, 1957			
5. SEX <input type="radio"/> male <input checked="" type="radio"/> female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Oct. 15, 1885		9. AGE (In years last birthday) 71 IF UNDER 1 YEAR Months Days IF UNDER 2 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 1951			10b. KIND OF BUSINESS OR INDUSTRY Colgate-Palmolive		11. BIRTHPLACE (City and State or Foreign Country) West Plains, Mo.			12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Dobson Ingold			13b. MOTHER'S MAIDEN NAME Nancy Jane Cox			14. NAME OF HUSBAND OR WIFE Mrs May Ingold			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. May Ingold 93 S. 16th K.C.K					
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) Cerebral Vascular Thrombosis ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____						INTERVAL BETWEEN ONSET AND DEATH 332X	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
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) Stanton City Jackson Mo					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR					
22. I hereby certify that I attended the deceased from <u>Jan 1, 1957</u> , to <u>March 9, 1957</u> , that I last saw the deceased alive on <u>March 9, 1957</u> , and that death occurred at <u>10:00 p.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title)? D. L. Shireman, M.D.				23b. ADDRESS 4606 St. John Kemo			23c. DATE SIGNED 3-11-57		
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 3/10/57		24c. NAME OF CEMETERY OR CREMATORY Highland Park Cemetery		24d. LOCATION (City, town, or county) (State) K.C. Kansas			
DATE REC'D BY LOCAL REG. 3-11-57		REGISTRAR'S SIGNATURE neva Marshall			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS JOS. A. BUTLER'S SONS K.C.K				

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

K. L. Shireman

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 *Ralph D. Groub*.....
Licensed Embalmer No. *5004*.....

P. O. Address *K. C. Kan.*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fail 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.