Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-007256
STATE FILE NUMBER

FEB 24 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 1352

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION: Peoples Hospital — Length of stay in Hospital: Life

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY:
c. CITY OR TOWN: St. Louis — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 4140a Cook Ave. — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: JOSEPHINE Middle: DANIELS Last: INGRAM

4. DATE OF DEATH: Month: Feb. Day: 5 Year: 1959

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Oct. 29, 1888
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (City and state or country): Montgomery City, Mo.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME: Joseph Daniels
13b. MOTHER'S MAIDEN NAME: ?
14. NAME OF HUSBAND OR WIFE: Preston Ingram

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Preston Ingram Address: 4140a Cook Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the Liver — INTERVAL BETWEEN ONSET AND DEATH: about 3 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 156.1
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Dec. 30, 1958, to Feb. 6, 1959 and last saw her/him alive on Feb. 5, 1959
Death occurred at 11:59 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: D. B. Key (Degree or title)
22b. ADDRESS: 4 So Compton
22c. DATE SIGNED: 2-6-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 2/9/59
23c. NAME OF CEMETERY OR CREMATORY: Washington Park Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis County, Mo.

24. FUNERAL DIRECTOR: Charles J. Gates, ADDRESS: 4107 Finney
25. DATE RECD. BY LOCAL REG.: FEB 9 '59
26. REGISTRAR'S SIGNATURE: Karl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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. 4580

P. O. Address 4107 Finney Av

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.