

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 31 1959

59-025211

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3446

DED

1. PLACE OF DEATH a. COUNTY <u>Jackson</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Length of stay in lb <u>38 years</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Joseph Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>3245 Spruce</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>D.</u> Last <u>INGRAM</u>			4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1959</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-13-1891</u>	9. AGE (last birthday) <u>68</u>	UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Optometrist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Optical</u>		11. BIRTHPLACE (City and state or country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Charles James Ingram</u>			13b. MOTHER'S MAIDEN NAME <u>Fannie Louise Quiggle</u>		14. NAME OF HUSBAND OR WIFE <u>Mildred Ingram</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>486-07-7843</u>		17. INFORMANT Address <u>Mildred Ingram - 3245 Spruce</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO (b) <u>Acute kidney failure (acute nephritis)</u> 5 days DUE TO (c) <u>after gastrectomy for duodenal ulcer</u> 9 days Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
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 <u>July 1 - 59</u> to <u>death</u> and last saw him alive on <u>July 12 - 59</u> Death occurred at <u>1:12 p</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Vincent Williams M.D.</u>				22b. ADDRESS <u>836 Argyle Blvd</u>			22c. DATE SIGNED <u>July 12 59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>July 15, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Maria Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>		
24. FUNERAL DIRECTOR <u>Hilke Funeral Home</u>			ADDRESS <u>2315 Penwood</u>		25. DATE RECD. BY LOCAL REG. <u>7-14-59</u>		26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>	

DOCUMENT

BY AFFIDAVIT OF Vincent T. Williams MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Chas E. Wilks

Licensed Embalmer No. 2644
P. O. Address 19 E. ...

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