

**FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH**

**59-040134**

**FILED VS DEC 10 1959**

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5536

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>	Length of stay in 1b <u>4 1/2 yrs</u>	c. CITY OR TOWN <u>Kansas City</u>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Marys Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>30 E. 32nd terr</u>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Lee</u> Last <u>Ingram</u>	4. DATE OF DEATH Month <u>Nov</u> Day <u>15</u> Year <u>1959</u>
---	---

5. SEX <u>Female</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>2-25-1938</u>	9. AGE (last birthday) <u>21</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>
----------------------	-------------------------------	---	-----------------------------------	----------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if unskilled) <u>P. O. Operator</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Bruno Ark.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A</u>
---	-----------------------------------	--	--

13a. FATHER'S NAME <u>Frank De Priest</u>	13b. MOTHER'S MAIDEN NAME <u>Ronna Keeter</u>	14. NAME OF HUSBAND OR WIFE <u>Robert 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>500-40-4926</u>	17. INFORMANT Address <u>Robert Ingram 30 E. 32nd terr</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>Ruptured cerebral aneurism</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	

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 checked="" 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.) <u>Two car collisions</u>
--	--	--

20c. TIME OF INJURY Hour _____ a.m. _____ p.m. <u>10:19 59</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>highway 402</u>	20f. CITY, TOWN, OR LOCATION <u>Higginsville</u>	COUNTY <u>Lafayette</u>	STATE <u>Missouri</u>
---	---	---	--	-------------------------	-----------------------

21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE (Degree or title) <u>Hugh H. Owens Coroner</u>	22b. ADDRESS <u>1034 Rialto Plaza</u>	22c. DATE SIGNED <u>11-17-59</u>
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Nov. 17 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bruno Ark</u>

24. FUNERAL DIRECTOR ADDRESS <u>D.W. Newcomer Sore N.C.</u>	25. DATE RECD. BY LOCAL REG. <u>11-17-59</u>	26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>
---	--	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 1961 AON SA

**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 John V. Henrich  
Licensed Embalmer No. 4548  
P. O. Address S. B. 17th

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.