

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-003960

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 506 STATE FILE NUMBER

FILED JAN 19 1962

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS CITY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Franklin</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CITY</u>		c. CITY OR TOWN <u>Robertsville</u>	
Length of stay in 1b <u>3 DAYS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>None - P.O. Box 205</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First	Middle	Last	Month	Day	Year
<u>FRANK</u>	<u>JACKSON</u>	<u>INGRAM</u>	<u>JANUARY</u>	<u>11</u>	<u>1962</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>11-30-1922</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Animal Husbandry</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>VETERINARIAN</u>	11. BIRTHPLACE (City and state or country) <u>Bonne Springs, Ka.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William R. Ingram</u>		13b. MOTHER'S MAIDEN NAME <u>Charity M.J. (nee: Wilburn)</u>		14. NAME OF HUSBAND OR WIFE <u>ARTA 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>502.0</u>		17. INFORMANT <u>SON: Don Ingram - St. Clair Mo.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>BRONCHO-PNEUMONIA</u>			<u>3 DAYS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>PULMONARY INSUFFICIENCY</u>		<u>7 YEARS</u>
	DUE TO (c) <u>CHRONIC BRONCHITIS WITH EMPHYSEMA</u>		<u>10 YEARS</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>502.0</u>		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 1954 to 1962 and last saw her/him alive on 1-11-62
Death occurred at 1 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>D. N. Smith M.D.</u>	22b. ADDRESS <u>BARNES HOSPITAL</u>	22c. DATE SIGNED <u>1-11-62</u>
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>JAN. 14, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MITCHELL - Robertsville</u>	23d. LOCATION (City, town, or county) (State) <u>Franklin County - Mo.</u>
---	-----------------------------------	--	---

24. FUNERAL DIRECTOR ADDRESS <u>Bell F.H. - Pacific, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>JAN 12 1962</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith M.D.</u>
--	--	---

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

Sec. 2, 110 03.11

FEB 19 1962

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 Byron J. Bell

Licensed Embalmer No. 4977

P. O. Address Pacific Mo

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.