

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-015282

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2362 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 14 1962

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| a. COUNTY Jackson | | a. STATE Missouri b. COUNTY Jackson | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | c. CITY OR TOWN Kansas City | |
| Length of stay in 1b 41 Years | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 401 East 36th Street Hyde Park Nursing Home | | d. STREET ADDRESS (If outside, give location) 6415 Wyandotte Street | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|---|------------------|--|-----------------------------|--|--|-----------------------------|--|
| 3. NAME OF DECEASED (Type or print) | | | 4. DATE OF DEATH | | | | |
| HALLIE E. INGRAM | | | April 27, 1962 | | | | |
| 5. SEX | 6. COLOR OR RACE | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HR | |
| Female | Cauc. | Widowed | 1/7/72 | 91 | Months | Days | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) | | 12. CITIZEN OF WHAT COUNTRY | |
| Housewife | | At Home | | Saline County, Mo. | | U.S.A. | |
| 13a. FATHER'S NAME | | | 13b. MOTHER'S MAIDEN NAME | | 14. NAME OF HUSBAND OR WIFE | | |
| George E. Mosley | | | Elizabeth F. Hancock | | Frank J. 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. | | 17. INFORMANT | | |
| No | | | None | | Mrs. Hazel Caraway | | |
| | | | | | Address 6415 Wyandotte Kansas City, Mo. | | |

| | | |
|---|--|----------------------------------|
| 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) CORONARY OCCLUSION | | |
| DUE TO (b) ARTERIO SCLEROSIS | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | |

| | | |
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| 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.) |
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| | | |
|---------------------|-----------|------------------|
| 20c. TIME OF INJURY | Hour | Month, Day, Year |
| | a.m. p.m. | |

| | | | | |
|---|--|------------------------------|--------|-------|
| 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.) | 20f. CITY; TOWN, OR LOCATION | COUNTY | STATE |
|---|--|------------------------------|--------|-------|

21. I attended the deceased from 1954 to 1962 and last saw her alive on 4:00 P. Death occurred at 4:00 P. on the date stated above, and to the best of my knowledge, from the causes stated.

| | | |
|---|---------------------------------------|---------------------------------|
| 22a. SIGNATURE Robert H. Hanes (Degree or title) | 22b. ADDRESS 7501 Mission Road | 22c. DATE SIGNED 4-25-62 |
|---|---------------------------------------|---------------------------------|

| | | | |
|---|--------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE Apr. 30, 1962 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Washington Cemetery | 23d. LOCATION (City, town, or county) Kansas City, Missouri |
|---|--------------------------------|---|--|

| | | |
|--|---|--|
| 24. FUNERAL DIRECTOR D.W. Newcomer's Sons, Kansas City, Mo. | 25. DATE RECD. BY LOCAL REG. 4-30-62 | 26. REGISTRAR'S SIGNATURE Ruth Long |
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VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF **Robert L. Hanes**

USE BLACK INK OR TYPEWRITER RIBBON

D. Hagner
Vol 3 - 3510

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 *Vern Lawler*

Licensed Embalmer No. 4915

P. O. Address KG 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.