

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-042705

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5573 STATE FILE NUMBER

FILED NOV 16 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH
 a. COUNTY Jackson
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City Length of stay in lb 70 yrs
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 9401 Blue River Rd. Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE Mo b. COUNTY Jackson
 c. CITY OR TOWN Kansas City Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) 9401 Blue River Rd. Reside on Farm Yes No

3. NAME OF DECEASED First Middle Last 4. DATE OF DEATH Month Day Year
EVALENA RENA INGRAM 10 31 1962

5. SEX Female 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 7/20/1879 9. AGE (last birthday) 83 IF 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) Housewife 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (City and state or country) Negginville, Mo 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME James Gilbey 13b. MOTHER'S MAIDEN NAME Nancy 14. NAME OF HUSBAND OR WIFE Joe Ingram

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) no 16. SOCIAL SECURITY NO. none 17. INFORMANT Barbara Clifton Address 17.C. Mo. rd 9401 Blue River

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Carcinosis Primary Pectus
 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. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 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 _____ Month, Day, Year _____ p.m.

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 _____ to _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Hugh H. Owens 22b. ADDRESS 152 Mission Station 22c. DATE SIGNED 11-26-62

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE 11/2/1962 23c. NAME OF CEMETERY OR CREMATORY Memorial Park 23d. LOCATION (City, town, or county) (State) Kansas City, Mo

24. FUNERAL DIRECTOR C. W. Blackman & Son ADDRESS _____ 25. DATE RECD. BY LOCAL REG. 11-2-62 26. REGISTRAR'S SIGNATURE Ruth Long

USE BLACK INK OR TYPEWRITER RIBBON

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

Hubert B. Baird

Licensed Embalmer No. 4888

P. O. Address TC 24, 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.