

12-3  
17-39

**FILED** AUG 14 1940

State File No. \_\_\_\_\_

Registration District No. 725

Primary Registration District No. 3009

Registrar's No. 231

1. PLACE OF DEATH:

(a) County Cape Girardeau,  
 (b) City or town Cape Girardeau, Mo.,  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution Southeast Missourian,  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 8 Hours 2  
(Specify whether)  
 In this community all his life  
years, months or days 25 years

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Scott  
 (c) City or town Sikeston, MO  
(If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Paul I. Ingram, 526

3. (b) If veteran, 499-01-1638 name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased May 15, 1915,  
(Month) (Day) (Year)

|                         |                 |                |  |
|-------------------------|-----------------|----------------|--|
| 8. AGE: Years <u>25</u> | Months <u>1</u> | Days <u>20</u> | If less than one day<br>hr. _____ min. _____ |
|-------------------------|-----------------|----------------|--|

9. Birthplace New Madrid Co.,  
(City, town, or county) (State or foreign country)

10. Usual occupation Salesman

11. Industry or business \_\_\_\_\_

12. Name Bert B. Ingram, D

13. Birthplace Groves Back, Texas,  
(City, town, or county) (State or foreign country)

14. Maiden name Ann Hollingsworth

15. Birthplace New Madrid Co., Mo.,  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Ann Ingram

(b) Address 403 Pennsylvania Sikeston MO

17. (a) Burial (b) Date thereof 7-7-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director J. A. Sempstead  
(b) Address Sikeston Mo

19. (a) 7-8-40 (b) J. A. Sempstead  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 5  
year 1940 hour 9 minute 30 a.m.

21. I hereby certify that I attended the deceased from July 5  
1940 to July 5, 1940  
that I last saw him alive on July 5, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Fracture of skull  
Fracture of left femur  
Fracture of left humerus  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Duration

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicidal (specify) Auto accident

(b) Date of occurrence 7-5-40

(c) Where did injury occur? Sikeston, Scott Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
On highway  
(Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury ✓

23. Signature H. Washley (M. D. or other) \_\_\_\_\_  
Address Cape Girardeau, Mo Date signed 7-8-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

6  
1  
4

210m  
95

CS 01-10-1988

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed G. A. Dempster  
Licensed Embalmer No. 2021  
P. O. Address Sikeston 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 this body is not embalmed, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **24808**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **125**

Primary Registration District No. **3009**

Registrar's No. **231**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Cape Girardeau**  
(b) City or town **Cape Girardeau**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_ (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Paul J. Ingram**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **s**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years **25** Months **1** Days **20** If less than one day, hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **5** year **1940** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death **Fracture of left femur**  
**Fracture of left femur**  
Due to **left humerus**

Due to **auto accident**

Other conditions (Include pregnancy within 3 months of death)

**Collision with other vehicle (Truck)**  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy **210 m**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **Accident**

(b) Date of occurrence **July 4 - 1940**

(c) Where did injury occur **Wentworth, Scott. Mo** (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **3 miles below Wentworth on highway**

While at work? **no** (Specify type of place) (e) Season of injury \_\_\_\_\_

23. Signature **H. W. Ashley** (M. D. or other) Address **Cape Girardeau** signed **no**

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

