STATE OF MISSISSIPPI

MISSISSIPPI STATE DEPARTMENT OF HEALTH
VITAL RECORDS

TYPE OR PRINT WITH BLACK INK

FILING DATE: DEC 11 1991

CERTIFICATE OF DEATH

STATE OF MISSISSIPPI

STATE FILE NUMBER: 123-

DECEASED

1. NAME First	Middle	Last	2. SEX	3a. HOUR OF DEATH	3b. DATE OF DEATH (Month, Day, Year)
Annie	Lounette	Ingram	Female	3:50 a. m.	Nov. 28, 1991

4. RACE (Specify White, Black, American Indian, etc.)	5a. AGE AT LAST BIRTHDAY	ONLY IF UNDER 1 YEAR 5b. MOS	5c. DAYS	ONLY IF UNDER 1 DAY 5d. HOURS	5e. MINS	6. DATE OF BIRTH (Month Day, Year)	7a. COUNTY OF DEATH
White	74 Years					June 17, 1917	Copiah

7b. CITY OR TOWN OF DEATH	7c. HOSPITAL OR OTHER INSTITUTION-NAME AND NUMBER (If not in either, give street address, route number or other location)	7d. IF IN HOSP., OR INST. SPECIFY INPT., OUTPT., EMER. RM,OR DOA	8. STATE OF BIRTH
Crystal Springs	Rt.1 Box 162-A		Ms

9. DECEDENT'S EDUCATION (Specify only highest grade completed)	Elem/High School (0-12)	College (1-4, 5+)	10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No)
	11		Married	James Ingram	No

13. ORIGIN OR DESCENT (Specify Cuban, Afro-American, Mexican, etc.)	14. SOCIAL SECURITY NUMBER	15a. USUAL OCCUPATION (Kind of work done most of working life)	15b. KIND OF BUSINESS OR INDUSTRY
American	425-10-6081	Housewife	own house

Death occurred in institution, see HANDBOOK, regarding completion of RESIDENCE items

RESIDENCE items, enter actual location if home rather than mailing address

16a. RESIDENCE—STATE	16b. COUNTY	16c. CITY OR TOWN	16d. INSIDE CITY LIMITS (Specify Yes or No)	16e. STREET AND NUMBER OR RURAL LOCATION
Ms	Copiah	Crystal Springs	No	Rt.1 Box 162-A

PARENTS

17. FATHER—NAME First	Middle	Last	18. MOTHER—NAME First	Middle	Maiden
N.B.	nmn	Alford	Susie	nmn	Overby

INFORMANT

19a. INFORMANT—NAME (Type or print)	19b. MAILING ADDRESS (Street and number or route and box number, City or town, State, ZIP code)
Mr. James Ingram, Sr.	Rt. 1 Box 162-A Crystal Springs, Ms 39059

DISPOSITION

20a. BURIAL, CREMATION, REMOVAL (Specify)	20b. CEMETERY, CREMATORY—NAME	20c LOCATION (City and State)	21a. EMBALMER—SIGNATURE AND NUMBER
Burial	County Line	Crystal Springs,Ms	F5223

21b. FUNERAL HOME—NAME AND MISSISSIPPI I.D. NUMBER	21c. MAILING ADDRESS (Street and number or route and box number, City or town, State, ZIP code)
Stringer Funeral Home 15-S	P.O.Box 431 Crystal Springs,Ms 39059

PRONOUNCEMENT

22a. PERSON WHO PRONOUNCED DEATH—NAME AND TITLE (Type or print)	22b. PRONOUNCED DEAD (Month, Day, Year)	22c. PRONOUNCED DEAD (Hour)
Jerri Brown	ON Nov. 28, 1991	AT 3:50 a. m.

CERTIFIER

23a. CERTIFIER—NAME (Type or print)	23b. MAILING ADDRESS (Street and number or route and box number, City or town, State, ZIP code)
Jerri Brown	Rt. 1 Bx 216 Crystal Springs

Mississippi State Board of Health Form No 511 Revised 1-1-89

This section to be completed by physician if NOT a medical examiner

24a. To the best of my knowledge, death occurred due to the cause(s) and manner as stated.
SIGNATURE ► MD

24b. DATE SIGNED (Month, Day, Year)

24c. STATE LICENSE NUMBER

24d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or print)

This section to be completed by medical examiner ONLY

24e. On the basis of examination and/or investigation, in my opinion, death occurred due to the cause(s) and manner as stated.
SIGNATURE ► Jerri Brown

24f. TITLE: CMEI

24g. DATE SIGNED (Month, Day, Year): Nov. 28, 1991

CAUSE OF DEATH

25. PART I. DEATH CAUSED BY:

Conditions, if any, which gave rise to immediate cause stating the underlying cause last

		Interval between onset and death
(a) IMMEDIATE CAUSE (Enter one cause only):	Ovarian Cancer	
(b) DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only):		
(c) DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only):		

26. PART II. OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not resulting in the underlying cause given in PART I: Anemia

27. AUTOPSY (Yes or No)

28. WAS CASE REFERRED TO MEDICAL EXAMINER? (Yes or No)

Use if death NOT due to natural causes

29a. ACCIDENT, SUICIDE, HOMICIDE, PENDING INVESTIGATION, OR UNDETERMINED (Specify)	29b. DATE OF INJURY (Month, Day, Year)	29c. HOUR OF INJURY	29d. DESCRIBE HOW OR BY WHAT MEANS INJURY OCCURRED
		m.	

29e. INJURY AT WORK (Yes or No)	29f. PLACE OF INJURY (Specify Home, Farm, Street, Factory, Office building, etc.)	29g. LOCATION Street or route number	City or town	State

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE ON FILE IN THIS OFFICE

STATE BOARD OF HEALTH

Alton B. Cobb, M.D.
STATE HEALTH OFFICER

DEC 13 1991

David Lohrisch
STATE REGISTRAR

THE GREAT SEAL OF THE STATE OF MISSISSIPPI

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