

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County..... *Franklin*
Township..... *Prairie*
City..... (No.
St. Ward)

Registration District No. *294*
Primary Registration District No. *V-418*

File No. *24703*
Registered No. *23*

2. FULL NAME

Benjamin Walter Havel
(a) Residence. No. St. Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>M</i>	4. COLOR OR RACE <i>W</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Mary Havel</i>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>11-2-1878</i>		
7. AGE YEARS <i>79</i>	MONTHS <i>8</i>	DAYS <i>21</i>
If LESS than 1 day, hrs. or min.		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <i>Farming</i> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Judson Mo</i>		
PARENTS	10. NAME OF FATHER <i>John H Havel</i>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Mo</i>	
	12. MAIDEN NAME OF MOTHER <i>Jessan Pratt</i>	
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Mo</i>		
14. INFORMANT (Address) <i>W. E. Reed - St. Clair</i>		
15. FILED <i>7/7 31</i> REGISTRAR <i>W. E. Reed</i>		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 7 1931*

17. I HEREBY CERTIFY, That I attended deceased from *July 7 1931* to *July 7 1931* that I last saw him alive on *7-7-1931* and that death occurred, on the date stated above, at *8 P. M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral Regurgitation
72A
(duration) *20* yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *J. J. W.*
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH.....
St. Clair

19. DID AN OPERATION PRECEDE DEATH? *no* DATE OF.....
WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical*
(Signed) *W. E. Reed* M. D.
7/7 1931 (Address) *St. Clair*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *W. E. Reed Cemetery* DATE OF BURIAL *7/8 1931*

20. URBERTAKER *Cady & Co -* ADDRESS *St. Clair*

WHITE PRINT, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

AUG 26 1931

TO THE HONORABLE
MEMBERS OF THE HOUSE OF REPRESENTATIVES
IN SENATE CHAMBERS

REPORT
OF THE
COMMISSIONERS OF THE
LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE HOUSE OF REPRESENTATIVES
MAY 15, 1890

1891