

WRITE PLAINLY, 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.

JUL 12 1939

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

20342
Do not use this space.

1. PLACE OF DEATH

(a) County..... / Registration District No. **791**
 (b) Township..... / Primary Registration District No. **1008**
 (c) City St. Louis or St. Louis (d) Street No. St. Johns Hospital St. Williston, Mo
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

¹⁵³ Jonathan C. Havens
 (a) Residence, No. 6422 Wellsmar Avenue St. WR Williston, Mo
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Adele M. Havens (Mauer)

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 6, 1881

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	57	8	1	

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Clerk M. K. & T
 9. Industry or business in which work was done, as saw mill, bank, etc. Railroad
 10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) St. Louis (STATE OR COUNTRY) Mo

FATHER 13. NAME Gustavus Howes Havens

14. BIRTHPLACE (CITY OR TOWN) Illinois (STATE OR COUNTRY) IL

MOTHER 15. MAIDEN NAME Elizabeth Hood

16. BIRTHPLACE (CITY OR TOWN) Scotland (STATE OR COUNTRY)

17. INFORMANT Jonathan C. Havens, Jr. (ADDRESS) 6422 Wellsmar Ave

18. BURIAL, CREMATION, OR REMOVAL PLACE Valhalla DATE June 10, 1939

19. FUNERAL DIRECTOR (NAME) Math. Hermann & Son (ADDRESS) 2161 East Fair Avenue

20. FILED JUN 9 1939 J. F. Bredich Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 7, 1939

22. I HEREBY CERTIFY, That I attended deceased from Nov 1938 to June 1939

I last saw him alive on June 7, 1939. Death is said to have occurred on the date stated above, at 7:40 PM

The principal cause of death and related causes of importance were as follows:

Chronic prostate gland 1938
 Other contributory causes of importance:
51

Name of operation Prostate Date of 7/10/39
 What test confirmed diagnosis? Biopsy Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify.....
 (Signed) W. B. Keppel, M. D.
 (Address) 4520 Olive St.

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.....

Ronald Hampton

Licensed Embalmer No.....

2987

P. O. Address.....

2161 E. Fair Av

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, above space should be left blank.