

Registration District No. **677**

Primary Registration District No. **4403**

1. PLACE OF DEATH:

(a) County Shelby
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
McFarland Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Ira Ray Havens

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan 20, 1940
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 1 17 hr. min.

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

10. Usual occupation farmer

11. Industry or business _____

12. Name Ira Havens

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

14. Maiden name Jane Brewster

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

16. (a) Informant Ira Havens
(b) Address Rural m

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-8-40 (Month) (Day) (Year)

(c) Place: burial or cremation Maconville Tenn

18. (a) Signature of funeral director Full Dan
(b) Address Rural m

19. (a) Mar 8, 1940 (Date received local registrar) (b) Geo. F. Myers (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shelby
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 7 year 1940 hour 1 minute 9 M.

21. I hereby certify that I attended the deceased from March 6, 1940 to March 7, 1940 that I last saw him alive on March 7, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Bacterial Pneumonia Duration 2

Due to Shelby

Due to _____

Other conditions 11/11
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature William H. Brewer (M. D. or other) 1
Address St. Johns Mo Date signed 3/8/40

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

31
2
1

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.

RECEIVED

District Health Officer No. 5,

District File Number 442 410

Date Filed 4/11/40

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.