V. S. No. 2
DM—9-4-41
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 19 1945

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10774

Registration District No. 333 — Primary Registration District No. 6115 — Registrar's No.

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

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0

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Rural Richland Fr

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: x 1

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether

In this community 5 days

years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott

(c) City or town Rural 100

(If outside city or town limits, write "RURAL")

(d) Street No. 0

(If rural, give location)

(e) Citizen of foreign country? No. 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Fannie Havener

3. (b) If veteran, name war x

3. (c) Social Security No. x

4. Sex F.A.A.

5. Color or race W

6. (a) Single, widowed, married, divorced Baby O

6. (b) Name of husband or wife .....

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

7. Birth date of deceased 1 (Month) 19 (Day) 1945 (Year)

8. AGE: Years | Months | Days 5 | If less than one day ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name D. V. Havener
13. Birthplace ..... (City, town, or county) Ark (State or foreign country)

MOTHER
14. Maiden name Connie Miller
15. Birthplace ..... (City, town, or county) Ark (State or foreign country)

16. (a) Informant J. M. Miller

(b) Address Sikeston Mo R#1 Box 162

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-25-45 (Month) (Day) (Year)

(c) Place: burial or cremation Cooperative Cem

18. (a) Signature of funeral director Wm Albertson

(b) Address Sikeston Mo.

19. (a) 3/14/45 (Date received local registrar) (b) Lonie Largent (Registrar's signature)

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MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 24 year 1945 hour 11 minute 30 A.M.

21. I hereby certify that I attended the deceased from 1/19/45, 19..., to 1/24/45, 19...; that I last saw her alive on ....., 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Congestive Colic	
Due to	
Due to 1234	
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 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? ..... (Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature [illegible] (M. D. or other) DO

Address Sikeston Mo Date signed 4/27/45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office
District File Number 345-7
Date Filed 3/16/4

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 Not Embalmed, Registered Apprentice No. ....., working under my personal supervision.

Signed John Allenton

Licensed Embalmer No. 2941

P. O. Address Alfenton Md

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.