No. 2
1/47
17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JUN 18 1947

Registration District No. 305

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 21990

Primary Registration District No. 6047 11452

Registrar's No.

1. PLACE OF DEATH:
(a) County: St. Charles
(b) City or town: Wentzville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community: Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: St. Chas Co 92
(c) City or town: ~~St. Louis~~ Wentzville
(If outside city or town limits, write "RURAL") 0
(d) Street No. ..... (If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: John J. Havey
3. (b) If veteran, name war: World War 1
3. (c) Social Security No.

4. Sex: Male 0
5. Color or race: W
6. (a) Single, widowed, married, divorced: M
6. (b) Name of husband or wife: Grace Havey
6. (c) Age of husband or wife if alive: 48 years
7. Birth date of deceased: August 11, 1898 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
47	10		hr. min.

9. Birthplace: St. Louis, Mo. (City, town, or county) (State or foreign country)
10. Usual occupation: Farmer
11. Industry or business: 0

FATHER
12. Name: Edw. W. Havey 4
13. Birthplace: Ireland (City, town, or county) (State or foreign country) /

MOTHER
14. Maiden name: Ellen C. Havey
15. Birthplace: — Missouri (City, town, or county) (State or foreign country) 0

16. (a) Informant: Arthur Havey
(b) Address: 1042 Veronica Ave
17. (a) burial (Burial, cremation, or removal) (b) Date thereof 6-13-1947 (Month) (Day) (Year)
(c) Place: burial or cremation: Calvary Cemetery
18. (a) Signature of funeral director: Harrigan & Sheahan
(b) Address: 4415 Washington Ave.
19. (a) 6-11-47 (Date received local registrar) (b) Miss Jess Lewis (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 9 year 1947 hour 4 PM minute ..... M.

21. I hereby certify that I attended the deceased from June 15, 1945 to June 9, 1947 that I last saw him alive on June 7, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral accident	2 hrs.
Due to: Hypertension Cardiac Vascular disease	2 yrs.
Due to: Cerebral spurs or Processes growing in brain	6 yrs.
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy:	

PHYSICIAN — Underline the cause of 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) 0
While at work? (e) Means of injury

23. Signature: Francis Conway (M. D. or other) MD
Address: 1257 N. Kingshighway Date signed: 6/10/47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9
District File Number
Date Filed 6/17/47

DEC 11 1953

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 John S. Kennedy

Licensed Embalmer No. 4194

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, fact should be so stated above.

No. 2B
571—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. July

Registration District No. 305 Primary Registration District No. 4402 Registrar's No.

1. PLACE OF DEATH:

(a) County St Charles

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

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME John J. Harvey

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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug 11 1899
(Month) (Day) (Year)

8. AGE: Years 47 Months 1 Days 28 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 6/11/47 (Date received local registrar) (b) Mrs Jess Lewis (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June 9 year 1947 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Due to

Due to

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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

S-21990