

FILED MAY 21 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16189

State File No.

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 433

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

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) Springfield		c. CITY (If outside corporate limits, write RURAL and give township) Springfield	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 2405 N. Elizabeth	
d. FULL NAME OF HOSPITAL OR INSTITUTION Springfield Baptist			
3. NAME OF DECEASED (Type or Print) a. (First) MARVIN		b. (Middle) EMMETT	
c. (Last) HAVILAND		4. DATE OF DEATH (Month) (Day) (Year) May 13 1951	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 19 1879
9. AGE (In years last birthday) 71		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Painter	11. BIRTHPLACE (State or foreign country) Mich.
12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Marye Haviland			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Mary Haviland		ADDRESS Springfield	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) acute coronary occlusion ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Probable arteriosclerotic cardiovascular disease. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
INTERVAL BETWEEN ONSET AND DEATH 96 hrs			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4201	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9 May 1951 , to 13 May 1951 , that I last saw the deceased alive on 13 May 1951 , and that death occurred at 8:45 a.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) William W. Wood M.D.		23b. ADDRESS 205 St Louis St. Springfield, Mo.	
23c. DATE SIGNED 5/14/51			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE May 15 1951	
24c. NAME OF CEMETERY OR CREMATORY Delaware Cemetery		24d. LOCATION (City, town, or county) (State) Birch Tree, Missouri	
DATE REC'D BY LOCAL REG. 5-15-51		REGISTRAR'S SIGNATURE M. E. Handley M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE J. W. Klingner & Co.		ADDRESS Springfield	

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. 4176

P. O. Address Springfield

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.