

FILED JUL 30 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24071

State File No.

BIRTH NO. _____ REG. DIST. NO. 294 PRIMARY REG. DIST. NO. 3007 Registrar's No. 171

1. PLACE OF DEATH a. COUNTY <u>Randolph</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Randolph</u>	
b. CITY OR TOWN <u>Moberly</u>		c. CITY OR TOWN <u>Moberly</u>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) <u>523 W. Carpenter</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Whitaker Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Della</u> b. (Middle) <u>Havenor</u> c. (Last) <u>Van Dyke</u>			4. DATE OF DEATH <u>July 17th 1954</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	
8. DATE OF BIRTH <u>Aug 26th 1887</u>		9. AGE (In years last birthday) <u>66</u>		10. UNDER 1 YEAR <u>10</u> MONTHS <u>10</u> DAYS <u>21</u> HOURS <u></u> MIN. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Illinois</u>
12. CITIZEN OF WHAT COUNTRY?					

13a. FATHER'S NAME <u>John Havenor</u>		13b. MOTHER'S MAIDEN NAME <u>Sabra Clark</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT'S SIGNATURE OR NAME <u>H.T. Havenor, Moberly, Mo</u> ADDRESS	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>arteriosclerosis</u>		DUE TO (b) _____			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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 7-13, 1954 to 7-17, 1954, that I last saw the deceased alive on 7-17, 1954, and that death occurred at 3:40 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>E. T. Whitaker M.D.</u>		23b. ADDRESS <u>Moberly, Mo</u>		23c. DATE SIGNED <u>7-19-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7-19-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Sunset Mem Gardens</u>	
24d. LOCATION (City, town, or county) (State) <u>Moberly, Mo</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mahan and Son, Moberly, Mo</u>		ADDRESS	
DATE REC'D BY LOCAL REG. <u>7-19-54</u>		REGISTRAR'S SIGNATURE <u>Paul Williams</u>		26. LICENSED EMBALMER'S STATEMENT ON REVERSE SIDE	

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

19 10 100

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 Frank D. Witt

Licensed Embalmer No. 3021

P. O. Address Proby, Mo

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.