

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **33660**

BIRTH NO. _____		REG. DIST. NO. <u>146</u>		PRIMARY REG. DIST. NO. <u>3026</u>		Registrar's No. <u>422</u>		
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>				
b. CITY OR TOWN <u>Independence</u>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>Independence</u>		d. Residence within limits of city or incorporated town? <input type="checkbox"/> Yes <input type="checkbox"/> No		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Independence Sanitarium</u>				e. STREET ADDRESS (If rural, give location) <u>219 East Walnut 700⁰</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary</u>			b. (Middle) <u>Bell</u>		c. (Last) <u>Havens</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 30 - 1955</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>April - 29 - 1877</u>		
9. AGE (In years last birthday) <u>78</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Delaware - Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Charles A. Richardson</u>			13b. MOTHER'S MAIDEN NAME <u>Elmira Burroughs</u>		14. NAME OF HUSBAND OR WIFE <u>Charles W. Havens</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Floyd R. Neal, Sr.</u> ADDRESS <u>Indep. Mo</u>				
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, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebrovascular hemorrhage</u>				DUE TO (b) _____				
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (c) <u>331X</u>				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				<u>Arteriosclerotic Heart disease</u>				
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) (Min.) _____		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 <u>5-14-</u> <u>1955</u> , to <u>10-30-</u> <u>1955</u> , that I last saw the deceased alive on <u>10-30-</u> <u>1955</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>Chas. F. Graboske, M.D.</u>				23b. ADDRESS <u>129 W. Lexington, Indep., Mo.</u>		23c. DATE SIGNED <u>10-31-55</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Nov 2-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u>		24d. LOCATION (City, town, or county) (State) <u>Indianapolis, Indiana</u>		
DATE REC'D BY LOCAL REG. <u>11-1-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Roland B. Speaks</u>		ADDRESS <u>Indep. Mo</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

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.....
Signature of Student Embalmer

Signed *A. Kenneth Peterson*.....

Licensed Embalmer No. *46*.....

P. O. Address *Indy, Ind.*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.