

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-010996  
STATE FILE NUMBER

2 2943  
Registration No.

FILED APR 6 1959 Registration District No. Primary Registration District No. Registrar No.

309  
1-57  
91  
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Park Lane Hospital		d. STREET ADDRESS 2621 N. Market	

3. NAME OF DECEASED (Type or print) Kattie Haven			4. DATE OF DEATH March 21, 1959		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 21, 1900	9. AGE (In years last birthday) 58	IF UNDER 1 YEAR Months Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) West Plains, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Tom Heard	13b. MOTHER'S MAIDEN NAME Floretta Moore	14. NAME OF HUSBAND OR WIFE Ray Haven
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Ray Haven, 2621 N. Market St.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage & Hypertension		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ 331X		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	STATE

21. I attended the deceased from 3-12-59 to 3-19-59 and last saw her/him alive on 3-19-59  
Death occurred at 3:45 AM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Frank J. Smith (Degree or title) M.D.	22b. ADDRESS 4930 Lindell Blvd.	22c. DATE SIGNED MAR 23 59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3-23-59	23c. NAME OF CEMETERY OR CREMATORY Local Cemetery	23d. LOCATION (City, town, or county) (State) Kennett, Mo.
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24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington Blvd.	25. DATE RECD. BY LOCAL REG. MAR 23 '59	26. REGISTRARY SIGNATURE Frank J. Smith, M.D.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Vector, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All causes in Part I must be causally related.

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 *Stanley A. Dixon* .....  
Licensed Embalmer No. *1193* .....  
P. O. Address *W.D.* .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.