

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 2 1959

59-035052

Registration District No. 1 Primary Registration District No. _____ Registrar's No. 325 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Knox</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Benton</u>		Length of stay in 1b	c. CITY OR TOWN <u>Hurdland</u>
c. FULL NAME OF (If NOT in hospital, give location) <u>U S #63 app. 3 1/2 miles So. of Kirksville, Mo.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>ADRAIN</u> Last <u>HAVILAND</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>27</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/25/80</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Iron Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Structural</u>		11. BIRTHPLACE (City and state or country) <u>Henry, Co. Iowa</u>	
12. CITIZEN OF WHAT COUNTRY <u>U S</u>		13a. FATHER'S NAME <u>Parry Haviland</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Jessop</u>	
14. NAME OF HUSBAND OR WIFE <u>Minnie</u>		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>484-14-7818</u>	
17. INFORMANT <u>Frank Haviland, Mt. Pleasant, Ia.</u>		17. ADDRESS		17. ADDRESS	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Fractured Skull, Left temporal area</u>		
DUE TO (b) <u>Broken neck, crushed chest, Fractured and seperation of the back between the 6th & 7th thoracic vertebra</u>		
DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>he apparently suffered a heart seizure got out of his car and fell on the highway, heart shows marked coronary sclerosis with occlusions</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
---	--	--	--

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>This man had a bad heart and was a diabetic he apparently suffered a seizure got out of his car and fell on to the highway where he was struck by an oncoming car, killing him instantly.</u>	
20c. TIME OF INJURY Hour <u>6:30 p</u> Month, Day, Year <u>10/27/59</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>US #63, 3 1/2 Mi. South of</u>	20f. CITY, TOWN, OR LOCATION <u>Kirksville, Adair, Mo.</u>

21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at 6:30 p on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Nova E. Foster</u> (Signature) <u>Nova E. Foster</u> Coroner		22b. ADDRESS <u>402 N. Elson, Kirksville, Mo.</u>		22c. DATE SIGNED <u>10/29/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10/30/59</u>	23c. NAME OF CEMETERY <u>Cater</u>	23d. LOCATION (City, town, or county) (State) <u>RFD Kirksville, Adair, Mo.</u>	
24. FUNERAL DIRECTOR <u>Nova E. Foster</u> ADDRESS <u>Kirksville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>10-30-1959</u>	26. REGISTRAR'S SIGNATURE <u>Deris W. Ratliff</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Nova E. Foster*
Nova E. Foster

Licensed Embalmer No. 4742

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