

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **1550**

AMENDED

FILED VS FEB 28 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH
 a. COUNTY _____
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **St. Louis** Length of stay in lb _____
 c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION **Alexian Brothers Hospital** Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE **Missouri** b. COUNTY **Scott**
 c. CITY OR TOWN **Morley** Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last
Amplies Millner Havens

4. DATE OF DEATH Month Day Year
February 15, 1961

5. SEX **Male** **6. COLOR OR RACE** **White** **7. Married** **Never Married** **Widowed** **Divorced**
8. DATE OF BIRTH **6/15/1872** **9. AGE (last birthday)** **88**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Retired Farmer**
10b. KIND OF BUSINESS OR INDUSTRY _____ **11. BIRTHPLACE** (City and state or country) **Allenville, Ill.**
12. CITIZEN OF WHAT COUNTRY **U.S.**

13a. FATHER'S NAME **Winslow Havens** **13b. MOTHER'S MAIDEN NAME** **Sarah Brotherton** **14. NAME OF HUSBAND OR WIFE** **Lillian**

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** **Barbara Pease, 4251 Grove** Address _____

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) **Acute cardiac failure** INTERVAL BETWEEN ONSET AND DEATH **2 days**
 DUE TO (b) **Terminal Bronch. Pneumonia** **2 days**
 DUE TO (c) **Arteriosclerosis of heart base** **5 yr.**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) **Cerebral sclerosis, Senile atrophy** **422.1**
 PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO
20a. ACCIDENT **SUICIDE** **HOMICIDE** **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. Month, Day, Year _____

20d. INJURY OCCURRED WHILE AT WORK **NOT WHILE AT WORK** **20e. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ **20f. CITY, TOWN, OR LOCATION** _____ **COUNTY** _____ **STATE** _____

21. I attended the deceased from **1/14/61** to **2/15/61** and last saw her/him alive on **2/15/61**
 Death occurred at **9 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE _____ (Degree or title) **22b. ADDRESS** **1901 Madison St** **22c. DATE SIGNED** **2/15/61**

23a. BURIAL, CREMATION REMOVAL (Specify) **Removal** **23b. DATE** **2-15-61** **23c. NAME OF CEMETERY OR CREMATORY** **Local Cemetery** **23d. LOCATION (City, town, or county)** **Morley, Mo.** (Site) _____

24. FUNERAL DIRECTOR **Albert H. Hoppe, Inc., 4700 Washington Blvd.** **ADDRESS** _____ **25. DATE RECD. BY LOCAL REG.** **FEB 15 1961** **26. REGISTRAR'S SIGNATURE** **Boyd Smith, M.D.**

MAR 14 1961

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 H. DeFourn

Licensed Embalmer No. 4193

P. O. Address St. Louis, 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.