

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 25 1959

59-041427

STATE FILE NUMBER

Registration District No. 305 Primary Registration District No. 6047 Registrar's No. 25

1. PLACE OF DEATH a. COUNTY <u>ST. CHARLES</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>QUILVER TWA</u> Length of stay in 1b <u>6 WEEKS</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>WENTZVILLE R2</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY _____ c. CITY OR TOWN <u>ST. LOUIS MO.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>2021 N. BROADWAY</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle _____ Last <u>HAVENER</u>				4. DATE OF DEATH Month <u>NOV.</u> Day <u>18</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 type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 17 1886</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FACTORY WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HARD BOARD MFG</u>		11. BIRTHPLACE (City and state or country) <u>GASCONADE</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>JOHN ANDREW HAVENER</u>			13b. MOTHER'S MAIDEN NAME <u>EMALINE CARROLL</u>			14. NAME OF HUSBAND OR WIFE <u>NONE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>489-16-379A</u>		17. INFORMANT Address <u>MRS. ALB. LOEPFE WENTZVILLE</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MEDULLARY FAILURE</u> DUE TO (b) <u>ANOXIA</u> DUE TO (c) <u>ADVANCED BRONCHOGENIC CARCINOMA OF LUNG</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>LEFT VENTRICULAR FAILURE</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 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. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <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		COUNTY _____ STATE _____			
21. I attended the deceased from <u>12-11-56</u> to <u>10-14-59</u> and last saw him alive on <u>10-16-59</u> Death occurred at <u>8.45</u> A.M. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Warren B. Hamilton D.D.</u>				22b. ADDRESS <u>WENTZVILLE, MO.</u>		22c. DATE SIGNED <u>11-23-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL + BURIAL</u>		23b. DATE <u>10-20-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LIBERTY CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>OWENSVILLE MO</u>	
24. FUNERAL DIRECTOR ADDRESS <u>GOTTENSTROETER FUNERAL HOME</u> <u>Method N.H. Winter</u>			25. DATE RECD. BY LOCAL REG. <u>Nov 20 1959</u>		26. REGISTRAR'S SIGNATURE <u>Arthur F. Puff</u>		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

