

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

8414

399

1. PLACE OF DEATH

County Jackson
Township Kant
City Kansas City (No. 5319)

Registration District No. 399
Primary Registration District No. 1002
City Charlotte

File No. _____
Registered No. 1258
St. _____ (Word)

2. FULL NAME

Clavel Harding Honeyoy
(a) Residence No. 5319 Charlotte St., _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb-5-1921

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. _____ min.
6 0 21

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Kansas City (STATE OR COUNTRY) Missouri

10. NAME OF FATHER O.H. Honeyoy

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Atchison (STATE OR COUNTRY) Kansas

12. MAIDEN'S NAME OF MOTHER Katherine Ashcraft

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Missouri

14. INFORMANT O.H. Honeyoy (Address) 5319 Charlotte St

15. FILED 3/27/27 M.H. Craive REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 26 1927

17. I HEREBY CERTIFY That I attended deceased from March 21 1927 to March 26 1927 that I last saw him alive on March 26 1927, and that death occurred, on the date stated above, at 5:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broncho Pneumonia
1000 (duration) yrs. mos. 8 da.

CONTRIBUTORY Cardiac Dilatation (Coronar) (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Phys. Diag.
(Signed) D.D. Staff M. D.
3/27 1927 (Address) 718 Riatta Bldg.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Forest Hill DATE OF BURIAL Mar-28 1927

20. UNDERTAKER Wm Newcomer Sons ADDRESS K. C. Mo.

THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Ref. 5733 Mc Gee Highland 6670