

REC'D SEP 28 1938

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

Do not use this space.

## 1. PLACE OF DEATH

County Phillips  
Township St. James  
City (No. \_\_\_\_\_) \_\_\_\_\_

Registration District No. 678  
Primary Registration District No. 5904

File No. 29735  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

## 2. FULL NAME

Evelyn M. Honea  
(a) Residence, No. \_\_\_\_\_ St., \_\_\_\_\_ Ward. \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)

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

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3-9-1859

7. AGE YEARS 79 MONTHS 5 DAYS 3 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Housewife  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) Pickens County (STATE OR COUNTRY) South Carolina

13. NAME John Porter

14. BIRTHPLACE (CITY OR TOWN) Not known (STATE OR COUNTRY) \_\_\_\_\_

15. MAIDEN NAME Mary Lewis

16. BIRTHPLACE (CITY OR TOWN) Not known (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT Louis Honea (ADDRESS) Bourbon mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Bourbon DATE Aug 14 1938

19. UNDERTAKER Civilians (ADDRESS) Bourbon mo

20. FILED 9-1- 1938 Elaine B. Hout Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 12 193822. I HEREBY CERTIFY, That I attended deceased from Jan - 1935 1935 to Aug 12 1938I last saw her alive on Aug 12 1938. Death is said to have occurred on the date stated above, at 1:30 a. m.

The principal cause of death and related causes of importance were as follows:

Ch. Myocarditis Date of onset \_\_\_\_\_Other contributory causes of importance: Ch. Interstitial NephritisName of operation no Date of \_\_\_\_\_What test confirmed diagnosis? Ch. Lab. Was there an autopsy? no23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? no Date of injury no, 1938Where did injury occur? no (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury noNature of injury no24. Was disease or injury in any way related to occupation of deceased? no

If so, specify \_\_\_\_\_

(Signed) E. A. Scott, M. D.(Address) St. James Hospital

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.



FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH

29735-  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Phelps Registration District No. 678  
 (b) Township St James Primary Registration District No. 3904 Registered No. \_\_\_\_\_  
 (c) City \_\_\_\_\_ (d) Street No. X St. James Hospital, St. James, Mo X St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Evelyn M Honea  
 (a) Residence, No. \_\_\_\_\_ St.  Courbon mo  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
79 5 3

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

FATHER  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_  
 13. NAME \_\_\_\_\_  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

MOTHER  
 15. MAIDEN NAME \_\_\_\_\_  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_  
 18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19 \_\_\_\_\_  
 19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_  
 20. FILED 10-22- 1939 Elsie B. Houk Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 17 1938

22. I HEREBY CERTIFY, That I attended deceased from 19\_\_\_\_ to 19\_\_\_\_  
 I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.  
 The principal cause of death and related causes of importance were as follows:  
Chr Myo Carditi Date of onset \_\_\_\_\_  
10/1  
 Other contributory causes of importance:  
Chr Interstitial Nephritis

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) E. A. Scott \_\_\_\_\_, M. D.  
 (Address) St James Hosp.

SUPPLEMENT

REGISTERED IN ALL STATES TO RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AND RETURNED BY C.M.V.

S-29735