

Registration District No. **31**

Primary Registration District No. **5315**

Registrar's No.

1. PLACE OF DEATH:

(a) County **Crawford**  
(b) City or town **Paris**  
(c) Name of hospital or institution **Contract**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **3 years** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **John J. Honauer**

3. (b) If veteran name war **John J. Honauer** 3. (c) Social Security No.

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Anna Honauer** 6. (c) Age of husband or wife if alive **5** years

7. Birth date of deceased **3** (Month) **5** (Day) **1866** (Year)

8. AGE: Years **74** Months **7 1/2** Days **10 20** If less than one day hr. min.

9. Birthplace **Chicago** (City, town, or county) **Ill.** (State or foreign country)

10. Usual occupation **Cooper**

11. Industry or business

MOTHER FATHER { 12. Name **John J. Honauer**  
13. Birthplace **Germany** (City, town, or county) (State or foreign country)  
14. Maiden name **Anna Honauer**  
15. Birthplace **Germany** (City, town, or county) (State or foreign country)

16. (a) Informant **Anna Honauer** (b) Address **Paris, Mo.**

17. (a) (Burial, cremation, or removal) **Cremated** (b) Date thereof **1/28 1941** (Month) (Day) (Year)

18. (a) Signature of funeral director **L. J. Jones** (b) Address **St. Louis, Mo.**

19. (a) **2-10-41** (Date received local registrar) (b) **L. J. Jones** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Crawford**  
(c) City or town **Paris** (If outside city or town limits, write "RURAL")  
(d) Street No. **0** (If rural, give location)  
(e) If foreign born, how long in U. S. A. **0** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **1** day **25** year **1941** hour **9** minute **0** M.

21. I hereby certify that I attended the deceased from **June 1**, 19**40**, to **Jan 25**, 19**41**, that I last saw him alive on **Jan 25**, 19**41**, and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of Liver**

Due to **468**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

**207** While at work? (Specify type of place) (e) Means of injury

23. Signature **A. B. Parker** (M. D. or other) **D**  
Address **St. Louis Mo** Date signed **1-27-41**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

800

RECEIVED

District Health Officer No. 5,

District File Number 241303

Date Filed \_\_\_\_\_

RECEIVED

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 \_\_\_\_\_

Registered Apprentice No. 2379

working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. 2379

P. O. Address Steelville, 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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 2370

Registration District No. 221

Primary Registration District No. 2315

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Crawford  
(b) City or town Zimmerman T.P.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... (Specify whether  
in this community..... (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME

John J. Hanover

3. (b) If veteran name war..... 3. (c) Social Security No.....

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year

7. Birth date of deceased Mar 2 - 1866  
(Month) (Day) (Year)

8. AGE: Years 75 Months 10 Days 20 If less than one day hr. min.

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 2-10-41 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....  
(c) City or town..... (If outside city or town limits write "RURAL")  
(d) Street No..... (If rural, give location)  
(e) If foreign born, how long in U. S. A.?..... years.

GENERAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 25 year 1947 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19..... to....., 19.....; that I last saw him..... alive on....., 19.....; and that death occurred on the date and hour stated above.  
Immediate cause of death.....

Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature P. C. Parker (M. D. or other).....

Address Steele Mo Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

