

Dr. W. E. Walker
State File No. 6897

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAR 11 1943

Registrar's No. 52

Registration District No. 166

Primary Registration District No. 5603

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

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1. PLACE OF DEATH:

(a) County Johnson

(b) City or town Rural - ground imp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 87 yrs -
(Specify whether years, months or days)

In this community 87 yrs -

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Johnson ⁵¹

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Betty S. Honey

3. (b) If veteran, name war _____

3. (c) Social Security No. none

4. Sex male 5. Color or race white

6. (a) Single, widowed, married 2 divorced widowed

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July - 15 - 1855
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>87</u>	<u>7</u>	<u>3</u>	hr. min.

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

10. Usual occupation Retired Farmers wife

11. Industry or business _____

MOTHER FATHER {

12. Name Wm. S. Honey

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

14. Maiden name Wm. M. Lee

15. Birthplace Ireland ⁴
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Olivia Honey

(b) Address Knob Noster Mo.

17. (a) Burial
(Burial, cremation, or other) (b) Date thereof Feb-19-43
(Month) (Day) (Year)

(c) Place: burial or cremation Knob Noster Cem.

18. (a) Signature of funeral director C. E. Sauls

(b) Address Knob Noster Mo.

19. (a) 2-18-43 (b) Mrs. C. E. Foster
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb ¹⁷ 1943
year _____ hour 10 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from May 1
1940 to Feb 17 ¹⁹⁴³

that I last saw her alive on Feb 16 ¹⁹⁴³
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Degeneration ^{3 yrs}

Due to _____

Due to _____

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

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

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 W. E. Walker (M. D. or other) MD
Address La Monte Mo. Date signed 2-19-43

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RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 3-6-43

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, C. L. Saults

Registered Apprentice No.

working under my personal supervision:

Signed

Licensed Embalmer No. 1086

P. O. Address Knob Noster 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, fact should be so stated above.