

V. S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X36571

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED DEC 5 1944

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH 1003

State File No. 35999

Registration District No. 318 Primary Registration District No. Registrar's No. 10123

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Bethesda General Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 18 days  
(Specify whether years, months or days) 0

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County 11  
(c) City or town St. Louis Mansfield  
(If outside city or town limits, write "RURAL")  
(d) Street No. NR.  
(If rural, give location)  
(e) Citizen of foreign country? 1 (Yes or No)  
If yes, name country 1

3. (a) PRINT FULL NAME Honeycutt, Jerry Lee  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W. 6. (a) Single, widowed, married, divorced U  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if all \_\_\_\_\_ years  
7. Birth date of deceased 9 16 1944  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
— 2 6 hr. min.

9. Birthplace St. Louis Mo.  
(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 Honeycutt Betty  
15. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Betty Honeycutt  
(b) Address Mansfield 2nd  
17. (a) Burial (b) Date thereof 11-30-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director V. B. Hudson  
(b) Address City Health Dept  
19. (a) 11-29-44 (b) J. F. Bredeek  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month November day 22  
year 1944 hour 9 minute 00 A. M.  
21. I hereby certify that I attended the deceased from November  
4, 1944 to November 22, 1944.  
that I last saw h. er. alive on November 22, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Otitis media, bilateral  
2 meningitis  
Due to Prematurity

Due to \_\_\_\_\_  
Other conditions 159  
(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 Dr. Wm. Riley St. Louis  
(M. D. or other) Address Bethesda General Hosp. Date signed 11/29/44

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

MOTHER FATHER

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.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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.**