

FILED DEC 13 1947

Registration District No. **360**

Primary Registration District No. **8225**

Registrar's No. **179**

1. PLACE OF DEATH:

(a) County Vernon  
(b) City or town Nevada  
(c) Name of hospital or institution: State Hosp 3 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 19 days  
(Specify whether years, months or days)  
In this community 19 days  
years, months or days)

3. (a) PRINT FULL NAME MINNIE HONN

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex female 5. Color or race wh. 6. (a) Single, widowed, married, divorced m.

6. (b) Name of husband or wife Ray Honn 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased March 21, 1886  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
61 8 12 - hr. - min.

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

10. Usual occupation Housewife

11. Industry or business none

12. Name Benjamin J. Ford

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

14. Maiden name Emily Dunham

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

16. (a) Informant Records State Hosp 3  
(b) Address Nevada, Mo

17. (a) Removed (b) Date thereof 12-4-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clinton Mo

18. (a) Signature of funeral director W. H. Johnson  
(b) Address Clinton Mo

19. (a) 12-4-47 (b) Halbur Yancy  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 4  
year 1947 hour 11 minute 30 AM

21. I hereby certify that I attended the deceased from Nov 15 1947 to Dec 4 1947  
that I last saw her alive on Dec 4 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Angina Pectoria  
Due to 94 lb.

Due to 94 lb.

Other conditions Mental Deficiency  
(Include pregnancy within 3 months of death)  
and Possible Epilepsy

Major findings: no operation

Of operations no autopsy

22. If death was due to external causes, fill in the following: no!

(a) Accident, suicide, or homicide (specify) no!

(b) Date of occurrence

(c) Where did injury occur? at home  
(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) (Means of injury)

23. Signature Paul L. Barone (M. D. or other)  
Address State Hosp 3 Date signed Dec 4

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

MOTHER FATHER

Duration

few minutes

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED  
District Health Officer No. 7,  
District The Registrar  
12-11-47  
Date filed 11-47-47

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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 Fred W. Peterson  
Licensed Embalmer No. 2478  
P. O. Address Osceola 7th

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.