

No. 300  
-10-47  
5-17-39  
I 3905

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

FEDERAL BUREAU OF INVESTIGATION  
National Office of Vital Statistics  
FILED SEP 27 1948  
Registration District No. 787

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 30334  
Registrar's No. 118

Primary Registration District No. 5697

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Rural - Richhill Twp.  
(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 1  
In this community Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. Richhill Twp.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3: (a) PRINT FULL NAME John Alexander Honey  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept day 5  
year 1948 hour 7 minute 50 P.M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to 5 Sept, 1948;  
that I last saw him alive on 5 Sept, 1948;  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased January 25 1887  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_  
Myocardial Failure  
Due to acute  
Bronchial asthma  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
61 7 10 \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace Jamestown Mo  
(City, town, or county) (State or foreign country)  
10. Usual occupation Farmer

PHYSICIAN  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER-FATHER  
11. Industry or business \_\_\_\_\_  
12. Name William L. Honey  
13. Birthplace \_\_\_\_\_ Kentucky  
(City, town, or county) (State or foreign country)  
14. Maiden name Nancy E. Wade  
15. Birthplace \_\_\_\_\_ Missouri  
(City, town, or county) (State or foreign country)  
16. (a) Informant Mrs. H. J. Eckert  
(b) Address Phillipsville, Mo.  
17. (a) Burial (b) Date thereof 9/8/48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mt. Pleasant Cemetery  
18. (a) Signature of funeral director Donald Gordon  
(b) Address Phillipsville, Mo.  
19. (a) Sept 27 48 (b) Frances B. Neill  
(Date received local registrar) (Registrar's signature)

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 V. V. Anderson (M. D. or other) \_\_\_\_\_  
Address Phillipsville, Mo. Date signed 7 Sept

1948

**DISTRICT HEALTH OFFICE  
Cameron, Mo.**

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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 *Ronald F. Gordon*

Licensed Embalmer No. 4191

P. O. Address *Chillicothe, 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.**