

FILED SEP 7 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **27371**  
**3942**  
Registrar's No. ....

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1007</u>		Registrar's No. ....		
1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>				
b. CITY OR TOWN <b>KANSAS CITY</b>		c. LENGTH OF STAY (in this place) <b>22 YEARS</b>		c. CITY OR TOWN <b>KANSAS CITY</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>TRINITY LUTHERAN HOSPITAL</b>				f. STREET ADDRESS <b>4600 S.C. NICHOLS PARKWAY 69 PARK LANE HOTEL</b> <span style="float:right">364 B</span>				
3. NAME OF DECEASED (Type or Print) <b>LOUIS ORAL HONIG</b>			4. DATE OF DEATH <b>AUGUST 13, 1954</b>					
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>NOV. 14, 1887</b>	9. AGE (In years last birthday) <b>66</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>REAL ESTATE AGENT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HONIG REAL ESTATE</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>BROWNSTOWN, ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13a. FATHER'S NAME <b>LOUIS YOLE HONIG</b>		13b. MOTHER'S MAIDEN NAME <b>CHRISTINA MILLER</b>		14. NAME OF HUSBAND OR WIFE <b>MABEL F. HONIG</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>495-03-0876</b>		17. INFORMANT'S SIGNATURE OR NAME <b>MRS. MABEL F. HONIG</b> ADDRESS <b>4600 S.C. NICHOLS PARKWAY, KANSAS CITY, MISSOURI</b>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc.: It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Gastric Ulcer</b>				DUE TO (b) <b>Hemorrhage, gastro.</b>				5 days.
ANTECEDENT CAUSES				DUE TO (c) <b>Intestinal</b>				- 400
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				<b>Essential hypertension</b>				3 yrs +
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <u>Aug 9, 1954</u> , to <u>Aug 13, 1954</u> , that I last saw the deceased alive on <u>Aug 12, 1954</u> , and that death occurred at <u>2:45 P.M.</u> , from the causes and on the date stated above.								
23a. SIGNATURE <b>Joseph E. Welker</b> (Degree or title) <b>MD</b>			23b. ADDRESS <b>836 Prof Bldg Kansas City Mo</b>			23c. DATE SIGNED <b>8-13-54</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>AUG-14-1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>FOREST HILL CEMETERY</b>		24d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>			
DATE REC'D BY LOCAL REG. <b>8-14-54</b>		REGISTRAR'S SIGNATURE <b>Geraldine Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>W.A. Neumann, Sr.</b> ADDRESS <b>731 BRUSH CREEK - KANSAS CITY, MISSOURI</b>				

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING, BLACK INK—MAKE A PERMANENT RECORD  
Joseph E. Welker M.D.

300  
48

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 ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed Rollie Kessel.....

Licensed Embalmer No. 469  
P. O. Address R. C......

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.