

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023794  
STATE FILE NUMBER

FILED JUN 22 1959 Registration District No. 324 Primary Registration District No. 6093 Registrar's No. 101

300  
1-57

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1. PLACE OF DEATH a. COUNTY <b>Saline</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Texas</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Marshall</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Cabool</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. State School</b>		Length of stay in lb <b>10 yrs.</b>	d. STREET ADDRESS _____ (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Betty</b> Middle <b>Jo</b> Last <b>Honeycutt</b>			4. DATE OF DEATH Month <b>June</b> Day <b>16</b> , Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> C WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-10-1927</b>	9. AGE (In years last birthday) <b>32</b>	FUNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Patient</b>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <b>Bellefonte, Arkansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>J. W. Honeycutt</b>		13b. MOTHER'S MAIDEN NAME <b>Thelma Trimble</b>		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. _____	17. INFORMANT Address <b>Mo. State School Records, Marshall, Mo.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Paralysis &amp; flexion deformity legs.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Since birth</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Birth injury</b>					
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>July 26, '46</b> to <b>June 16, '59</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>June 16, '59</b> Death occurred at <b>900 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Arthur B. Day M.D.</b>			22b. ADDRESS <b>Missouri State School, Marshall, Mo.</b>		22c. DATE SIGNED <b>6-17-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>6-17-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cabool cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Cabool, Missouri</b>
24. FUNERAL DIRECTOR <b>Cambell-Lewis, Marshall, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>6-17-'59</b>		26. REGISTRAR'S SIGNATURE <b>Cecil G. Reed</b>	

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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 *James A. Lewis* .....  
Licensed Embalmer No. *4709* .....  
P. O. Address *Marshall, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.