MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

60-007647
STATE FILE NUMBER

FILED VS MAR 15 1960

Registrar's District No. 290 Primary Registration District No. _____ Registrar's No. 29

1. PLACE OF DEATH
a. COUNTY: PULASKI
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: WAYNESVILLE — Length of stay in 1b: 5 DAYS
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): GENERAL HOSPITAL — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO — b. COUNTY: WEBSTER
c. CITY OR TOWN: NIANGUA MO RI — Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): 6 MI N.E. — Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First: DEWEY — Middle: AB — Last: HONEYCUTT

4. DATE OF DEATH: Month: JAN — Day: 7 — Year: 1960

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 5-26-1898

9. AGE (last birthday): 61 — IF UNDER 1 YEAR: Months ____ Days ____ — IF UNDER 24 HR: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: ——

11. BIRTHPLACE (City and state or country): MISSOURI

12. CITIZEN OF WHAT COUNTRY: U.S.A

13a. FATHER'S NAME: WASH. HONEYCUTT

13b. MOTHER'S MAIDEN NAME: NETTIE WILLHITE

14. NAME OF HUSBAND OR WIFE: MARY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): UNKNOWN — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: UNKNOWN

17. INFORMANT — Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	MYOCARDIAL FAILURE, ACUTE	24 HOURS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. — DUE TO (b)	HEPATIC ABSCESS, PERFORATED DUODENAL	1 MONTH
DUE TO (c)	ULCER, PERITONITIS.	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 _____, to _____ and last saw her/him alive on _____

Death occurred at 11:45 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): [illegible], M.D.

22b. ADDRESS: Richland, Mo.

22c. DATE SIGNED: 1-20-60

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

23b. DATE: 1-7-1960

23c. NAME OF CEMETERY OR CREMATORY: GOOD SPRINGS

23d. LOCATION (City, town, or county) (State): WEBSTER Co MO

24. FUNERAL DIRECTOR — ADDRESS: BARBER-EDWARDS MARSHFIELD

25. DATE RECD. BY LOCAL REG.: 3-3-60

26. REGISTRAR'S SIGNATURE: Carla Mae Anderson

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT — MEDICAL CERTIFICATION — BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed b

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____
Signature of Student Embalmer

Licensed Embalmer No._____ 38

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
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.