

FEDERAL BUREAU OF INVESTIGATION  
 FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
 FILED VS DEC 13 1960

-60-042782

STATE FILE NUMBER

Registration District No. 207 Primary Registration District No. \_\_\_\_\_ Registrar's No. 51

1. PLACE OF DEATH a. COUNTY <del>Marion</del> <b>Marion</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Marion</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <del>Rolla</del> <b>Spring Creek</b>		Length of stay in 1b <b>29 Yrs.</b>		c. CITY OR TOWN <b>Rolla</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Route No. 3 Rolla Mo.</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Route 3</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>SARAH</b> Middle <b>ANN</b> Last <b>HONSE</b>				4. DATE OF DEATH Month <b>December</b> Day <b>2</b> Year <b>1960</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>11-5-83</b>	9. AGE (last birthday) <b>77</b>	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) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>xx</b>		11. BIRTHPLACE (City and state or country) <b>Polk County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>Joseph Davis</b>			13b. MOTHER'S MAIDEN NAME <b>Sarah Duncan</b>			14. NAME OF HUSBAND OR WIFE <b>Robert H. Honse.</b>			
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. <b>xx</b>		17. INFORMANT <b>Mrs. John Snyder, Sikeston, Mo.</b>			Address	
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>Cerebral Vascular Accident</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>		
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.		Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <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>1959</b> to <b>Dec 2, 1960</b> and last saw her alive on <b>Dec 1, 1960</b> Death occurred at <b>5:30AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>S. J. Anderson MD</i> (Degree or title)				22b. ADDRESS <b>Rolla Mo</b>			22c. DATE SIGNED <b>12/14/60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-4-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ozark Memorial Gardens</b>		23d. LOCATION (City, town, or county) (State) <b>Rolla, Missouri.</b>				
24. FUNERAL DIRECTOR By <i>S. J. Anderson</i> ADDRESS <b>Rolla</b>			25. DATE RECD. BY LOCAL REG. <b>12-4-1960</b>		26. REGISTRAR'S SIGNATURE <i>Thoyelle Hutchison</i>				

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 by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed S. L. Muel  
\_\_\_\_\_

Licensed Embalmer No. 3397

P. O. Address Rochester, N.Y.

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.