

FILED JUL 7 1944  
Registration District No. 1000

Primary Registration District No. 1000

Registrar's No. 685

1. PLACE OF DEATH:  
(a) County Buchanan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Missouri Methodist Hospital  
(If not in hospital or institution, write street number or location) 0  
(d) Length of stay: In hospital or institution 5 days (Specify whether  
In this community 5 days years, months or days)

3. (a) PRINT FULL NAME Violet Schoneman  
3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife George D. Schoneman 6. (c) Age of husband or wife if alive 42 years  
7. Birth date of deceased November 22 1908  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>35</u>	<u>7</u>	<u>8</u>	____ hr. ____ min.

9. Birthplace Rockport Missouri  
(City, town, or county) (State or foreign country)  
10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_  
12. Name Theodore Caudle  
13. Birthplace Rockport Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Olive Bartholomew  
15. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant George D. Schoneman  
(b) Address Rockport, Missouri.

17. (a) Removal (b) Date thereof 6/30/1944  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Rockport Missouri

18. (a) Signature of funeral director Walter Meischoffer  
(b) Address 1302 Faraon St., St. Joseph, Mo.

19. (a) 6/30/44 (b) Helen J. Gekke  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Atchison 3  
(c) City or town Rockport 1  
(If outside city or town limits, write "RURAL") 0  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_ 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30th.  
year 1944 hour 6:30 minute P. M.

21. I hereby certify that I attended the deceased from 6-26-44 to 6-30, 1944,  
that I last saw her alive on 6-30-, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Embolic, pulmonary

Due to Operation 3 days

Due to Cholecystitis 3 yrs

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Infected gall bladder.

Of autopsy None.

DURATION  
for  
3 weeks

PHYSICIAN  
\_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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) (c) Means of injury \_\_\_\_\_

23. Signature Paul Jorgensen (M. D. or other) 0  
Address St. Joseph Mo. Date signed 7-1-44

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

MOTHER FATHER

**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 *Albert C. Harrington*

Licensed Embalmer No 3258 Missouri

P. O. Address St. Joseph, Missouri.

**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.**