

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36869**

FILED DEC 9 8 1945

Registration District No. 9

Primary Registration District No. 5218

Registrar's No. 42

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

1. PLACE OF DEATH:

(a) County CASS
(b) City or town BIG CREEK WAMP
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
7 MILES WEST PLEASANT HILL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether
In this community LIFE (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CASS ¹⁹
(c) City or town PLEASANT HILL "RURAL"
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME TRAVIS EARL COLVILLE

3. (b) If veteran, name war WORLD WAR I 3. (c) Social Security No. ✓

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife ARNITA McCoy COLVILLE 6. (c) Age of husband or wife if alive 37 years
7. Birth date of deceased FEB. 11 1895
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
50 9 10 hr. min.

9. Birthplace CASS Co. Mo. D
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business

12. Name CHARLES C. COLVILLE
13. Birthplace ST CLAIR Co. ILLINOIS
(City, town, or county) (State or foreign country)
14. Maiden name JOAN BELLE KIMBRELL
15. Birthplace ILLINOIS
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. T. EARL COLVILLE

(b) Address R#4, PLEASANT HILL, MO.

17. (a) BURIAL (b) Date thereof 11-24-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation WILLS, PECULIAR, MO

18. (a) Signature of funeral director G. K. George & Sons
(b) Address Bella, Mo.

19. (a) Nov 28, 1945 (b) Samuel J. Jones.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 21st
year 1945 hour 5 minute 300 M.

21. I hereby certify that I attended the deceased from July 1944 to Nov 21, 1945
that I last saw him alive on Nov 9, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death. Coronary Thrombosis
Chronic myocarditis

Other conditions. (Include pregnancy within 3 months of death)

Major findings: Of operations 920
Of autopsy _____

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) (e) Means of injury 9

23. Signature J. L. Hancock M. D. or other _____
Address Pleasant Hill, Mo. Registered 11-24-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1433

(Licensed Embalmer's Statement on Reverse Side)

Records

DEC 1 1945

DEC 12 1945

JAN 7 1946

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 *A. K. George*

Licensed Embalmer No. *3645*

P. O. Address *Grandview, 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 this body is not embalmed, fact should be so stated above.