

FILED JUN 13 1946

Registration District No. 59

Primary Registration District No. 5218

1. PLACE OF DEATH:

(a) County CASS  
(b) City or town BIG CREEK TOWNSHIP  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
7 mi. West Pleasant Hill  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community LIFE  
years, months or days

3. (a) PRINT FULL NAME JOHN BELLE COLVILLE

3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

4. Sex FEMALE 5. Color or race WHITE  
6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife CHAS. C. COLVILLE  
6. (c) Age of husband or wife if alive 7 years

7. Birth date of deceased JAN 7 1870  
(Month) (Day) (Year)

8. AGE: Years 76 Months 4 Days 12  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation AT HOME

11. Industry or business \_\_\_\_\_

12. Name NELSON L. KIMBELL

13. Birthplace ILLINOIS  
(City, town, or county) (State or foreign country)

14. Maiden name HANNAN DAVIS

15. Birthplace ILLINOIS  
(City, town, or county) (State or foreign country)

16. (a) Informant ANGIE BELLE COLVILLE

(b) Address RD 4 PLEASANT HILL Mo

17. (a) BURIAL (b) Date thereof MAY 19 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation WILLS Cem. Peculiar Mo

18. (a) Signature of funeral director E. R. Group + Sons  
(b) Address Peculiar Mo

19. (a) MAY 20 1946 (b) KATHERINE J. JONES  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CASS  
(c) City or town PLEASANT HILL, RFD #4  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
7 mi. West Pleasant Hill  
(If rural, give location)  
(e) Citizen of foreign country?  (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 17  
year 1946 hour 12: minute 30 P.M.

21. I hereby certify that I attended the deceased from MAY 1 1946  
to MAY 17 1946  
that I last saw her alive on MAY 17 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis  
Duration 7

Due to: \_\_\_\_\_

Due to: \_\_\_\_\_

Other conditions Edema Lungs - Hypertension  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy 930

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 \_\_\_\_\_

23. Signature Martin V. Robbins (M. D. or other) MD

Address Peculiar, Mo Date signed 5/19/46

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

14890

9  
0  
0

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

---

---

**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..... *Scandinavia 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.**