

DEPARTMENT OF COMMERCE
BUREAU OF PUBLIC HEALTH
FILED AUG 29 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 251

Primary Registration District No. 3048

Registrar's No. 170

1. PLACE OF DEATH:

(a) County Madison
(b) City or town Marionville Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Francis Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 hr 30 mins
(Specify whether _____)
In this community 1 yr
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Madison
(c) City or town Marionville
(If outside city or town limits, write "RURAL")
(d) Street No. 2
(If rural, give location) _____
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME GEORGE WARREN VIOLETT

3. (b) If veteran, name war No 3. (c) Social Security No. 593-03-1220

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 6 1881
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
66 3 30 hr. min.

9. Birthplace Marionville Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Carpenter

11. Industry or business Edgar Park Cals

12. Name George H Violet

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

14. Maiden name Nancy Ann Brown

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

16. (a) Informant Raymond Roberts

(b) Address Marionville Mo

17. (a) Removal (b) Date thereof 8-8-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Francis Hospital

18. (a) Signature of funeral director S. M. Atchison

(b) Address Marionville Mo

19. (a) 8-16-1947 (b) Bess Holt
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 5 year 1947 hour 14 minute 40 AM

21. I hereby certify that I attended the deceased from 6 May 1947 to Aug 5 1947, that I last saw him alive on 4 Aug 1947, and that death occurred on the date and hour stated above.

Immediate cause of death Septic emboli, presumably thrombotic

Due to Arteriosclerotic heart disease 4 yrs.?

Due to _____

Other conditions Arteriosclerotic, slight
(Include pregnancy within 3 months of death)

Major findings: Of operations not made

Of autopsy not had

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 Chas. D. Humber (M. D. or other) MD

Address Marionville Date signed 8/9/47

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

MOTHER FATHER

SEP 24 1968

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 G. M. Catterman

Licensed Embalmer No 2279

P. O. Address Marionville 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.