

102
AUG 7 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

27129
Do not use this space.

1. PLACE OF DEATH

(a) County Cameron Registration District No. 875
(b) Township Washington Primary Registration District No. 6162
(c) City or _____ (d) Street No. _____ St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred _____ yrs. mos. da. (f) How long in U.S., if of foreign birth? _____ yrs. mos. da.

2. PRINT FULL NAME

William Jolly
(a) Residence, No. State Hosp #3, Nevada Mo. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single.

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) ?

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
74 ? ? ?

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Scotland
America.

FATHER 13. NAME Ed Jolly

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Scotland

MOTHER 15. MAIDEN NAME Eliz. French

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland.

17. INFORMANT (ADDRESS) Helping Hand R.C.Mi.

18. BURIAL, CREMATION, OR REMOVAL PLACE Hope Park DATE July 1 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Billings 7 N Nevada Mo.

20. FILED 7-31 1939 Allen & Hays Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-30 1939

22. I HEREBY CERTIFY, That I attended deceased from 11-24 1937, to 7-30 1939.
I last saw him alive on 7-30 1939. Death is said to have occurred on the date stated above, at 9:40 pm.
The principal cause of death and related causes of importance were as follows:

Chf Myocarditis. Date of onset _____

Other contributory causes of importance: Senility
Arterio-sclerotic Pyelosis.

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____ 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) Ad. Kasanagh M. D.
795 Address State Hosp #3 Nevada Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 7;
District File Number 7-39-1142
Date Filed 8-4-39

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 *Mark Lechinger*

Licensed Embalmer No. 2656

P. O. Address Nevada 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, above space should be left blank.