

S. No. 2
DM-5-43
v. 5-17-39
I X36671

FILED NOV 18 1946

Registration District No. **59**

Primary Registration District No. **4097**

Registrar's No. **162**

1. PLACE OF DEATH:

(a) County Cass

(b) City or town Harrisonville
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community 3 years
years, months or days

3. (a) PRINT FULL NAME MARY SI JOLLEY

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 B.B. Jolley

6. (c) Age of husband or wife if alive _____ years
(Month) (Day) (Year)

7. Birth date of deceased Jan 18 1856
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>90</u>	<u>9</u>	<u>13</u>	<u>1</u> hr. <u>0</u> min.

9. Birthplace St Charles Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

MOTHER FATHER

11. Industry or business _____

12. Name James M. Austin

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

14. Maiden name Unknown?

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

16. (a) Informant Sister - Harrison

(b) Address Harrisonville Mo

17. (a) Burial (b) Date thereof 11-3-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Orion Cemetery

18. (a) Signature of funeral director RUNNENBURGER'S

(b) Address HARRISONVILLE, MO.

19. (a) 11-3-1946 (b) Laura J. Jones
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cass

(c) City or town Harrisonville
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____
(Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 1
year 1946 hour 10:00 minute 4 M.

21. I hereby certify that I attended the deceased from Jan 1945
to Oct 27 1946
that I last saw h.c.k. alive on Oct 27 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Heart Failure Duration _____

Due to advanced arteriosclerosis and Senility

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: 97

Of operations _____

Of autopsy _____

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)

(e) Means of injury 2

23. Signature Paul Green (M. D. or other) MD
Address Harrisonville, Mo Date signed 11/4/46

Dr Green 51 (Licensed Embalmer's Statement on Reverse Side)

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

35166

OCT 2 1956

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 _____

Licensed Embalmer No. 3368

P. O. Address Harrisonville 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.