

FILED JUL 10 1947

254

4385

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Oregon  
 (b) City or town Rosharon  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
(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)

3. (a) PRINT FULL NAME

William Henry Jolliff

3. (b) If veteran.  name war.....

3. (c) Social Security No. 11

4. Sex ma 5. Color or race W 6. (a) Single, widowed, married, divorced. 1

6. (b) Name of husband or wife Arminia M. Jolliff 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased Feb 24 1866  
(month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>81</u>	<u>2</u>	<u>15</u>	hr. min.

9. Birthplace Centralia Ill  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

12. Name Rasmus Jolliff

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

14. Maiden name Martha Waipman

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

16. (a) Informant W. A. Cowens

(b) Address West Plains, Mo

17. (a) 3 (b) Date thereof 5-11-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jolliff Cem

18. (a) Signature of funeral director Robertson

(b) Address West Plains, Mo

19. (a) 7-14-47 (b) Edith Cross  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Oregon 75  
 (c) City or town Rosharon 0  
(If outside city or town limits, write "RURAL") 0  
 (d) Street No. (If rural, give location) 0  
 (e) Citizen of foreign country? (Yes or No)  
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 9  
 year 1947 hour 4 minute 20 P.M.

21. I hereby certify that I attended the deceased from 4/29 1947, to 5/9 1947,  
 that I last saw him alive on May 5th 1947  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 1 wk

Due to Arterio-Sclerosis

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 283

Of autopsy none

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) no

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 Arthur J. ... (M. D. or other)

Address West Plains, Mo Date signed 5/12/47

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

X

RECEIVED

District No. 5,

District No. 747315

Date Filed 7-8-47

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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.....

Geo. R. Drago....., Registered Apprentice No. 431  
working under my personal supervision.

Signed D. D. Robertson.....

Licensed Embalmer No. 3435

P. O. Address West Plains, 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.**

State File No. July  
Registrar's No. \_\_\_\_\_

Registration District No. 254

Primary Registration District No. 4885

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

1. PLACE OF DEATH:

(a) County Oregon

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

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

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Wm H Joliff

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased Feb 24 1908  
(Month) (Day) (Year)

8. AGE: Years 81 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER {

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 7-14-1947 (b) Edith Grass  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_ (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 \_\_\_\_\_ Day \_\_\_\_\_ Year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M. 9

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

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

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

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

PHYSICIAN \_\_\_\_\_

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

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

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

S-21785