

FILED AUG 10 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24209

BIRTH NO. 76517-53 REG. DIST. NO. 21 PRIMARY REG. DIST. NO. 3012 Registrar's No. 99

6002

1. PLACE OF DEATH
a. COUNTY CLAY
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN EXCELSIOR SPRINGS
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION EXCELSIOR SPRINGS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE MISSOURI b. COUNTY CLAY
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN EXCELSIOR SPRINGS
d. STREET ADDRESS (If rural, give location) 101 PENN ST.

3. NAME OF DECEASED
a. (First) ROBERT b. (Middle) WAYNE c. (Last) JOLLEY

4. DATE OF DEATH (Month) (Day) (Year) JULY 24, 1953

5. SEX MALE 6. COLOR OR RACE WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) INFANT 2

8. DATE OF BIRTH OCT 23, 1952

9. AGE (In years last birthday) 9 10. UNDER 1 YEAR Months 9 11. UNDER 24 HRS. Hours 1 12. UNDER 1 MIN. Min. 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE

10b. KIND OF BUSINESS OR INDUSTRY NONE

11. BIRTHPLACE (State or foreign country) KANSAS CITY MO 0

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME OLIVER L. JOLLEY

13b. MOTHER'S MAIDEN NAME WILDA MAY SCHRIENER

14. NAME OF HUSBAND OR WIFE NONE SINGLE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) NO NO

16. SOCIAL SECURITY NO. NO

17. INFORMANT'S SIGNATURE OR NAME ADDRESS M.D. Jolley, 101 Penn. Ex. Bldg.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute pulmonary edema
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Massive aspiration of vomitus
DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH 3 hrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 24, 1953, to July 24, 1953, that I last saw the deceased alive on July 24, 1953, and that death occurred at 7:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE George E. Sanden MD (Degree or title)

23b. ADDRESS Ex celcior Springs, Mo

23c. DATE SIGNED 7-29-53

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE JULY 26/53

24c. NAME OF CEMETERY OR CREMATORY SUNNY SLOPE

24d. LOCATION (City, town, or county) (State) RICHMOND, RAY MO

DATE REC'D BY LOCAL REG. 7/29/53

REGISTRAR'S SIGNATURE Caroline Hutchings

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HOPE FUNERAL HOME 101 Penn. Ex. Bldg. Ma

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

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed *Chas. Virgil Hope*.....

Licensed Embalmer No. *3950*.....

P. O. Address *Evolution Springs*.....

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.