FILED NOV 22 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36480

BIRTH NO. _____ REG. DIST. NO. 114 PRIMARY REG. DIST. NO. 5432 Registrar's No. 56

1. PLACE OF DEATH
a. COUNTY: FRANKLIN C
b. CITY OR TOWN: SULLIVAN (RN) (township)
c. LENGTH OF STAY (in this place): 5 YRS.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MISSOURI
b. COUNTY: FRANKLIN
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): SULLIVAN
d. STREET ADDRESS (If rural, give location): RURAL R. #2

3. NAME OF DECEASED (Type or Print)
a. (First): VIOLA
b. (Middle): MARY
c. (Last): JERROLD

4. DATE OF DEATH (Month) (Day) (Year): NOV. 14, 1955

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: SEPT. 19, 1884
9. AGE (In years last birthday): 71 — If under 1 year: Months 1 Days 21 — If under 24 hrs.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (State or foreign country): ST. FRANCIS CO.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: ALEXANDER RARIDEN
13b. MOTHER'S MAIDEN NAME: SARAH F. CLOUD
14. NAME OF HUSBAND OR WIFE: deceased THOMAS JEFFERSON JEROLD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT'S SIGNATURE OR NAME: VERNON JERROLD — **ADDRESS**: SULLIVAN, MO.

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b), and (c)

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

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 Hrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) _____

DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

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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* 11-10, 1955, *to* _____, 19____, *that I last saw the deceased alive on* 11-10, 1955, *and that death occurred at* 9:45 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Donald K. Smith D.O.
23b. ADDRESS: Sullivan Mo
23c. DATE SIGNED: 11-12-55

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: 11-12-55
24c. NAME OF CEMETERY OR CREMATORY: BUFFALO CEMETERY
24d. LOCATION (City, town, or county) (State): SULLIVAN, MO.

DATE REC'D BY LOCAL REG.: 11-12-55
REGISTRAR'S SIGNATURE: Thomas G. Humphrey M.D. 496
25. FUNERAL DIRECTOR'S SIGNATURE: H. Weaver — **ADDRESS**: Sullivan, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed D. A. Humphrey

Licensed Embalmer No. 4772

P. O. Address Sullivan Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.