49283-56

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42598
STATE FILE NUMBER

FILED DEC 28 1956 Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 435

1. PLACE OF DEATH
a. COUNTY ST. FRANCOIS
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN RURAL ST. FRANCOIS — Inside Limits Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give location) MINERAL AREA OSTEOPATHIC HOSPITAL — Length of stay in Hospital 1 day

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY ST. FRANCOIS
c. CITY OR TOWN MINERAL POINT 940 — Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First RAYMOND Middle STEVEN Last JOLLY

4. DATE OF DEATH Month DEC. Day 9 Year 1956

5. SEX MALE **6. COLOR OR RACE** WHITE **7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH 7-28-56

9. AGE (In years last birthday) IF UNDER 1 YEAR: Months 4 Days 11 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) FARMINGTON, MISSOURI

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

13. FATHER'S NAME CLARENCE JOLLY

14. MOTHER'S MAIDEN NAME Laurine Otto

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

16. SOCIAL SECURITY NO. NONE

17. INFORMANT Address Clarence Jolly, Mineral Point, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia bilateral (primary) — INTERVAL BETWEEN ONSET AND DEATH 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 491.X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 12-9-56, to 12-9-56 and last saw her/him alive on 12-9-56
Death occurred at 12-9-56 at 9:20 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) W. D. Morris, D.O. 2
22b. ADDRESS Elvins, Mo.
22c. DATE SIGNED 12-10-1956

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 12-11-56
23c. NAME OF CEMETERY OR CREMATORY New Masonic Cemetery
23d. LOCATION (City, town, or county) Potosi (State) Missouri

24. FUNERAL DIRECTOR ADDRESS SMITHS FUNERAL HOME POTOSI, MO.
25. DATE RECD. BY LOCAL REG. Dec. 10, 1956
26. REGISTRAR'S SIGNATURE Esther Rudloff

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, Coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was er

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Donnell B. Dietrich

Licensed Embalmer No. 41

P. O. Address Debato

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

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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