

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-015034

STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 141 Primary Registration District No. 5551 Registrar's No. 73

FILED MAY 8 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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20460-

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>mo</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brandsville</u>		Length of stay in 1b <u>64 yrs</u>	c. CITY OR TOWN <u>Brandsville</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Adolph</u> Middle <u>Lee</u> Last <u>Jolliff</u>			4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>62</u>
5. SEX	6. COLOR OR RACE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-18-97</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life/ even if retired) <u>live stock dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>64</u>
11a. FATHER'S NAME <u>Elijah Jolliff</u>		11b. MOTHER'S MAIDEN NAME <u>Alphretta Faulkner</u>	11. BIRTHPLACE (City and state or country) <u>Oregon Co mo</u>
12a. NAME OF HUSBAND OR WIFE <u>meda Jolliff</u>		12. CITIZEN OF WHAT COUNTRY	
13. SOCIAL SECURITY NO.		14. ADDRESS	
15. WAS RECALLED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Melburn Jolliff</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 _____ to _____ and last saw her/him alive on _____ Death occurred at <u>10 45</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Beatrice Cook Registrar</u>		22b. ADDRESS <u>West Plains mo</u>	
22c. DATE SIGNED <u>4-30-62</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>	
23b. DATE <u>4-29-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Jolliff</u>	
23d. LOCATION (City, town, or county) <u>Rover mo.</u>		23e. STATE	
24. FUNERAL DIRECTOR <u>Robertson's West Plains mo.</u>		25. DATE RECD. BY LOCAL REG. <u>5-1-62</u>	
26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>			

**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 \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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

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