

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 25 1960

=60-026622

STATE FILE NUMBER

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 186

1. PLACE OF DEATH a. COUNTY <u>Henry</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Henry</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clinton</u>		Length of stay in 1b <u>40 yrs.</u>	c. CITY OR TOWN <u>Clinton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Clinton Gen. Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>706 Park Ave</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>WALTER</u> Last <u>JOLLEY</u>			4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1960</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-17-1882</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>6</u>		IF UNDER 24 HR Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (City and state or country) <u>Wasson Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Jessie D Jolley</u>		13b. MOTHER'S MAIDEN NAME <u>Angie Puddy</u>		14. NAME OF HUSBAND OR WIFE <u>Minnie B Jolley</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>500-10-5845</u>		17. INFORMANT <u>Minnie B Jolley</u> Address <u>Clinton Mo.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u>						<u>3 days.</u>		
DUE TO (b) <u>Cerebral Hemorrhage</u>						<u>5 days.</u>		
DUE TO (c) <u>arteriosclerotic arterios & Heart</u>						<u>2 years.</u>		
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 checked="" 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 <u>-</u> a.m. <u>-</u> 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 <u>July 10, 1958</u> to <u>July 23, 1960</u> and last saw him alive on <u>July 22, 1960</u> Death occurred at <u>12:05 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Dr. R. S. Halligan M.D.</u>				22b. ADDRESS <u>Clinton Missouri</u>		22c. DATE SIGNED <u>7/23/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>July 24 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fields Creek</u>		23d. LOCATION (City, town, or county) <u>Henry County Mo.</u>				
24. FUNERAL DIRECTOR <u>F.L. SCHABERG CLINTON, MO.</u>			25. DATE RECD. BY LOCAL REG. <u>July 23 1960</u>		26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed F. L. Schaberg

Licensed Embalmer No. 451

P. O. Address Clinton

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to
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.