2154

ARIZONA STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF COMMERCE
BUREAU OF CENSUS

State File No. 2177
Registrar's No. 2175

1. Place of Death: (a) County MARICOPA (b) City or Town PHOENIX (If outside city limits also write RURAL) (c) Location VET. ADM. HOSPITAL (St. & No. (or) Name of Institution)

(d) Length of Stay: In Hospital or Institution since 10-22-46 Community 31 years (Specify whether years, months or days); In Arizona 31 years

2. Usual Residence of Deceased: (a) State ARIZONA; (b) County MARICOPA; (c) City or Town PHOENIX (If outside city limits also write RURAL)

(d) Street No. Luhrs Hotel, Phoenix, Arizona; (e) Citizen of foreign country (Yes or No) ____ If Yes, which country ____

3. (a) FULL NAME JOLLEY, William A. (b) If Veteran name war WWI (c) Social Security No. 527 24 4675

4. Sex: M

5. Race: White ☐ Indian ☐ Negro ☐ Oriental ☐

6. (a) Single, married, widowed or divorced: Widowed

6. (b) Name of husband or wife: ------

6. (c) Age of husband or wife, if alive ____ yrs.

7. Birthdate of deceased May (Month) 13 (Day), 1890 (Year)

8. AGE: Years 56 | Months 7 | Days 5 | If less than one day hrs. ____ min. ____

9. Birthplace Wisconsin (City, town or county) (State or Country)

10. Usual Occupation Civil Engineer

11. Industry or Business ____

Father: 12. Name George H. Jolley (Dec'd)
13. Birthplace Wisconsin (City, town or county) (State or Country)

Mother: 14. Maiden Name Margaret Nolan (dec'd)
15. Birthplace Kentucky (City, town or county) (State or Country)

16. (a) Informant's own signature Paul E. Travis, M.D.
osp. records & Paul E. Travis, M.D.
(b) Address Ward Surgeon, VA Hospital Phoenix, Ariz.

17. (a) Burial, Cremation or Removal Removal
(b) Place Prescott, Ariz. (c) Date Dec 23 1946

18. (a) Embalmer's Signature Tyler Hays #269
(b) Funeral Director A. L. Moore & Sons
(c) Address 333 W. Adams, Phoenix, Arizona

19. (a) DEC 20 1946 (Date received Local Registrar)
(b) Ernest J. Schweikhardt M.D. (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH (Month, day and year) December 18, 1946
TIME (Hour and minute) 6:15 A.M.

21. I hereby certify that I attended the deceased from October 22, 1946 to Dec. 18, 1946, that I last saw him alive on December 18, 1946, and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of sigmoid

Due to ____

Due to ____

Other conditions Tabes Dorsalis, Heart Disease (Include pregnancy within three months of death)

Major findings: Of operations ____

Of autopsy Confirmed above

DURATION: 2½ mo. or longer

PHYSICIAN: Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide (specify) ____
(b) Date of occurrence ____
(c) Where did injury occur? (City or Town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury ____

23. Signature R. A. GUNTER, M.D. CLINICAL DIRECTOR M. D.
Address VA Hospital, Phoenix, Arizona Date signed 1-2-47

40M—100% Rag—6-45