

No. 2
4-13-40
-17-39
X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **34842**
Registrar's No. **1105**

Registration District No. **85** Primary Registration District No. **1001**

FILED NOV 12 1940

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph
(c) Name of hospital or institution: St. Joseph's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
In this community 40 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Ruth Estaline Sollars
3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color, or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife James W. Sollars 6. (c) Age of husband or wife if alive 41 years
7. Birth date of deceased February 15, 1900
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>40</u>	<u>8</u>	<u>2</u>	hr. <u> </u> min. <u> </u>

9. Birthplace Ridgeway Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business At Home

12. Name Ira W. Rinehart

13. Birthplace Ridgeway Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Pearl E. Hoylman

15. Birthplace Cainsville Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant James W. Sollars

(b) Address 2826 Seneca Str. St. Joseph, Mo.

17. (a) Burial (b) Date thereof Oct. 19, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem't

18. (a) Signature of funeral director H. O. Sidenfaden & Son

(b) Address 1802 Union Str. St. Joseph, Mo.

19. (a) 10/21/40 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 2826 Seneca Street
(If rural, give location)
(e) If foreign born, how long in U. S. A. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 17th
year 1940 hour 4 minute 45 P. M.

21. I hereby certify that I attended the deceased from Oct 12
1940 to Oct 17, 1940;
that I last saw her alive on Oct 17, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia Duration Oct 14 -

Due to

Due to

Other conditions Paralytic ileus Oct 16-40
(Include pregnancy within months of death)

Major findings of operation Heart appears - Normal
Splenic - small fibrous infarct
Of autopsy
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?

(e) 85 (Specify type of place)
White or mark? (Specify type of place) (g) Means of injury

23. Signature [Signature] (M. D. or other)
Address St. Joseph, Mo. Date signed 10/18/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *Robert P. Clarkson*

Licensed Embalmer No. *4028*

P. O. Address *St. Joseph, Mo.*

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