No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17090

FILED JUN 1 1948

Registration District No. 251

Primary Registration District No. 3048

Registrar's No. 130

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

1. PLACE OF DEATH:
(a) County Nodaway
(b) City or town Maryville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Frances Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Andrews 2
(c) City or town Amazonia 0
(If outside city or town limits, write "RURAL")
(d) Street No. 1
(If rural, give location)
(e) Citizen of foreign country? no (~~Yes~~ or No)
If yes, name country

3. (a) PRINT FULL NAME John Sollars
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex M O
5. Color or race W
6. (a) Single, widowed, married, divorced W 2
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 3 (Month) 17 (Day) 1856 (Year)

8. AGE: Years	Months	Days	If less than one day
92	2	1	hr. min.

9. Birthplace Buchanan Co Mo (City, town, or county) (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER
12. Name Un Known 9
13. Birthplace Un Known (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Un Known 9
15. Birthplace Un Known (City, town, or county) (State or foreign country)
16. (a) Informant Samuel Sollars
(b) Address Nodaway Mo
17. (a) B. (Burial, cremation, or removal) (b) Date thereof 5-21-48 (Month) (Day) (Year)
(c) Place: burial or cremation Amazonia Mo
18. (a) Signature of funeral director E. C. Brent
(b) Address Savannah Mo
19. (a) 5-22-48 (Date received local registrar) (b) Bess Holt (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 18 year 1948 hour 10 minute 15 P. M.
21. I hereby certify that I attended the deceased from 5-5, 1948, to 5-18, 1948; that I last saw him alive on 5-18, 1948; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic myocarditis	
Due to Arteriosclerosis	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN
Underline the cause of 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 0
23. Signature Lowell Crowe (M. D. or other)
Address Savannah Mo Date signed 5-19-48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 E. C. Breit

Licensed Embalmer No. 2600

P. O. Address Savannah Mo

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

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