

FILED SEP 9 1957

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 958

300 X  
-57

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Joseph</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>2705 Lafayette St.</u>		Length of stay in 1b <u>65 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>707 South 7th St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED <u>Wyatt Park Nursing Home</u> (Type or print)		Last <u>Bell</u>	4. DATE OF DEATH Month <u>Sept.</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 7, 1872</u>	9. AGE (In years last birthday) <u>85</u> IF UNDER 1 YEAR Months <u>11</u> Days <u>17</u> IF UNDER 24 HRS. Hours <u>11</u> Min. <u>17</u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self employed</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Practical Nurse</u>	11. BIRTHPLACE (City and state or country) <u>Columbus, Ohio</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>(Unknown) Tudor</u>	13b. MOTHER'S MAIDEN NAME <u>Martha (Unknown)</u>	14. NAME OF HUSBAND OR WIFE <u>S abert H. Sollars</u>
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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>none</u>	17. INFORMANT Address <u>Warren Sollars, St. Joseph, Mo.</u>
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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>Congestive Heart Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypertensive Arteriosclerotic Cardiovascular renal disease</u>	?
	DUE TO (c) <u>Cerebro-vascular Accident (Hemorrhage)</u>	<u>1 wk</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>442x</u>		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> Month, Day, Year a.m. <u>          </u> p.m. <u>          </u>	

20d. INJURY OCCURRED WHILE AT <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 <u>          </u> COUNTY <u>          </u> STATE <u>          </u>
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21. I attended the deceased from 11-7-49 to 9-3-57 and last saw her/him alive on 9-1-57  
Death occurred at 6:05 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Warren Sollars</u> (Degree or title)	22b. ADDRESS <u>316 North St Joseph Mo</u>	22c. DATE SIGNED <u>9-4-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept. 5, 1957.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Meierhoffer-Fleeman Inc. St. Joseph, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Sept 5, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs Robert Fulton</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Albert E. Harrington* .....

Licensed Embalmer No. .... 3258 .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.