

No. 2  
-2-43  
5-17-39  
X35697

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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11272

State File No. ....

FILED APR 12 1944

Registration District No. 106

Primary Registration District No. 2001

Registrar's No. 156-

1. PLACE OF DEATH: *Jasper*

(a) County *Jasper*

(b) City or town *Jasper*  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
*211 E. 4th St. 1*  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution *30 years*  
(Specify whether years, months or days)

In this community *30 years*  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MISSOURI* (b) County *Jasper* 49

(c) City or town *Joplin* 2  
(If outside city or town limits, write "RURAL") 5

(d) Street No. *211 E. 4th*  
(If rural, give location)

(e) Citizen of foreign country? *No.* (Yes or No)

If yes, name country *—*

3. (a) PRINT FULL NAME *DR. GEORGE W. SOLLARS*

3. (b) If veteran, name war *—*

3. (c) Social Security No. *—*

4. Sex *Male* 5. Color or race *White* 6. (a) Single, widowed, married, divorced *Widowed*

6. (b) Name of husband or wife *—* 6. (c) Age of husband or wife if alive *—* years

7. Birth date of deceased *APRIL 14 1863*  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

*80 11 3*

hr. min.

9. Birthplace *FANNING Kansas*  
(City, town, or county) (State or foreign country)

10. Usual occupation *Chiro. Practor*

11. Industry or business

12. Name *Sabert Sollars*

13. Birthplace *St Joseph Mo*  
(City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace *Mary F. Jones*  
(City, town, or county) (State or foreign country)

16. (a) Informant *John H. Sollars*

(b) Address *116 So. Michigan Blvd. Chicago*

17. (a) *Burial* (b) Date thereof *3-20-44*  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Oskarve Memorial*

18. (a) Signature of funeral director *Thornhill Dixon*

(b) Address *Joplin, Mo.*

19. (a) *3-20-44* (b) *Quintus Sushalter*  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *March*, day *17*  
year *1944* hour *10* minute *45* P.M.

21. I hereby certify that I attended the deceased from *3/15* 19*44* to *3/17* 19*44*  
that I last saw him alive on *3/15* 19*44*  
and that death occurred on the date and hour stated above.

Immediate cause of death *myocardial with aortic dilatation of heart*

Due to *nephritis*

Due to

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

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?

While at work? (Specify type of place) (e) Means of injury

23. Signature *Clude B. Stangle* (M.D. or other) *M.D.*

Address *416 Grisco Bldg. Joplin* Date signed *3/20/44*

1204

44-3-263

**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 Cecil A. Thomhill

Licensed Embalmer No. 3590

P. O. Address Joplin, 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. April  
Registrar's No. 156

Registration District No. 156

Primary Registration District No. 2001

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Joplin  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME George W. Sallan

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Apr. 14 1886  
(Month) (Day) (Year)

8. AGE: Years 80 Months 11 Days \_\_\_\_\_ (Unless than one day) min. \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March Year 1944 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to Chronic nephritis of possibly several years duration

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

22. If death was due to external causes, fill in the following:

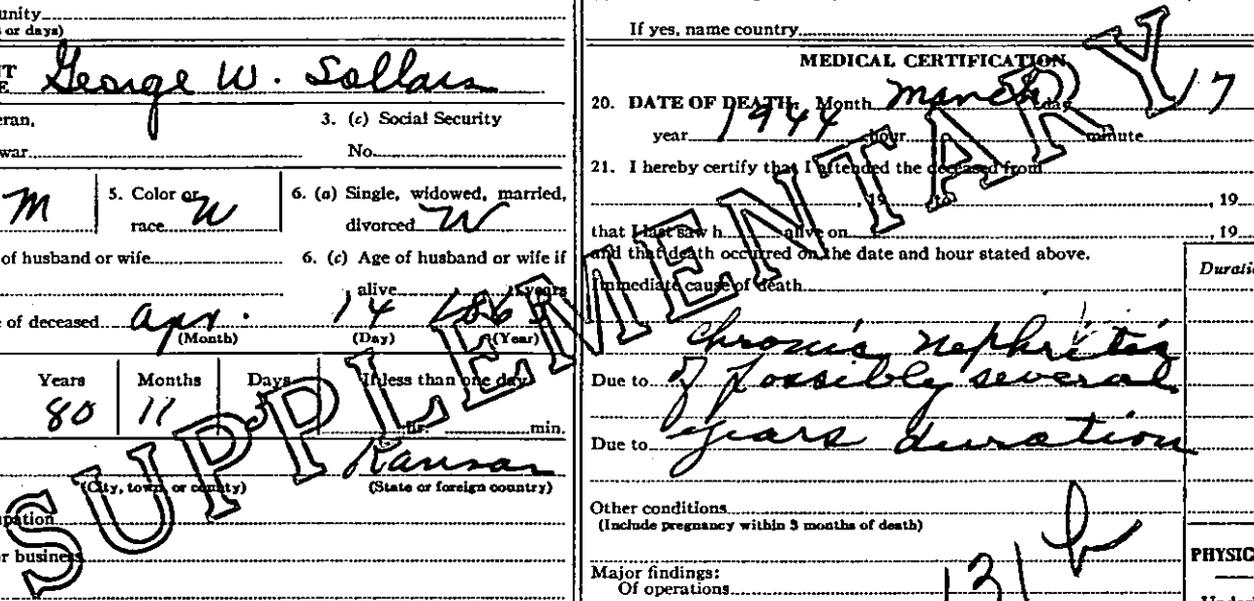
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(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? \_\_\_\_\_

23. Signature Clyde P. ... (M. D. or other) DO  
Address \_\_\_\_\_ Date signed \_\_\_\_\_



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

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