

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-025801
STATE FILE NUMBER 3195

FILED JUL 17 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY Bates	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		c. CITY OR TOWN ADRIAN 00700	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION V.A. HOSPITAL		d. STREET ADDRESS (If outside, give location) +	
Length of stay in lb 1 day		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED First Middle Last 4. DATE OF DEATH Month Day Year
GUY O. SOLLARS DEATH 6th 27th 1958

5. SEX Male 6. COLOR OR RACE White 7. MARRIED NEVER MARRIED
WIDOWED DIVORCED 8. DATE OF BIRTH - 9. AGE (In years last birthday) 63 yrs

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 10b. KIND OF BUSINESS OR INDUSTRY Agriculture 11. BIRTHPLACE (City and state or country) Sycamore, Kansas 12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Jim H. Sollars 13b. MOTHER'S MAIDEN NAME Hattie Mumford 14. NAME OF HUSBAND OR WIFE Freda Sollars

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI 16. SOCIAL SECURITY NO. none 17. INFORMANT Address VA Hospital Records, K.C., Mo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) *Comp. Fract. of Hemorrhage*
DUE TO (b) *Compound fracture both legs*
DUE TO (c) *Contusion Chest & Hemorrhage Pharynx*
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
Postesternal Slouch by Car

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. *6:27 58* 009

20d. INJURY OCCURRED WHILE AT NOT WHILE AT WORK 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) *Adrian* 20f. CITY, TOWN, OR LOCATION COUNTY STATE *MO*

21. I attended the deceased from _____ to _____ and last saw her alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) *Hugh H. Owens, D.M.S.* 22b. ADDRESS *1034 Pualto Bldg* 22c. DATE SIGNED *6-28-58*

23a. BURIAL, CREMATION, REMOVAL (Specify) *Removal* 23b. DATE *6-29-58* 23c. NAME OF CEMETERY OR CREMATORY *Luxemburg Hill Cem Adrian Mo* 23d. LOCATION (City, town, or county) (State)

24. FUNERAL DIRECTOR ADDRESS *Luxemburg Hill Cem Adrian Mo* 25. DATE RECD. BY LOCAL REG. *6-28-58* 26. REGISTRAR'S SIGNATURE *Hera Marshall*

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
Hugh H. Owens

300
1-57



DEC 17 1958

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 *John P. Dickman*

Licensed Embalmer No. *4531*
P. O. Address *Kansas City*

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.