MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

40131

File No. .....

Registered No. 27

JAN 23 1929

1. PLACE OF DEATH

County: Mississippi

Township: Central

City: ..... (No. ..... St. ..... Ward)

Registration District No. 294

Primary Registration District No. V 40973

2. FULL NAME: Alfred Peter Sorensen

(a) Residence. No. ..... St., ... Ward. St Louis Mo
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Minnie Sorensen

6. DATE OF BIRTH (MONTH, DAY AND YEAR): May 20 1884

7. AGE: Years 44 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (CITY OR TOWN): Fontenay
(STATE OR COUNTRY): Denmark

PARENTS

10. NAME OF FATHER: A. F. Sorensen

11. BIRTHPLACE OF FATHER (CITY OR TOWN):
(STATE OR COUNTRY): Denmark

12. MAIDEN NAME OF MOTHER: Maud Thalen

13. BIRTHPLACE OF MOTHER (CITY OR TOWN):
(STATE OR COUNTRY): Denmark

14. INFORMANT: Minnie Sorensen
(Address): St Louis Mo

15. FILED: 12/15-28, 19..... W. E. Kilebrew
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Dec - 14 1928

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19..... that I last saw h..... alive on ..... 19..... and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Murder, at the hands of Partial unknown
(Correct Injury Killed) (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED: —

IF NOT AT PLACE OF DEATH? .....

9 DID AN OPERATION PRECEDE DEATH? — DATE OF —

WAS THERE AN AUTOPSY? Yes - Removal of Bullet from Brain

WHAT TEST CONFIRMED DIAGNOSIS? .....

12/14 (Signed) W. K. Duenwald, M. D
, 192 (Address) St Louis Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Mount Zion

DATE OF BURIAL: 12-15 1928

20. UNDERTAKER: Wm Duenwald

ADDRESS: St Louis Mo

No. 2.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Franklin — Registration District No. 294 — File No.
Township Central — Primary Registration District No. 5409-B — Registered No. 27
City (No. , St. Ward)

2. FULL NAME Alfred Peter Sorensen
(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dont-Know

7. AGE: YEARS 44 — MONTHS — DAYS — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED N-29, 19 W. E. Mitchell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 14 1928

17. I HEREBY CERTIFY, That I attended deceased from , 19 to , 19 that I last saw h alive on , 19 , and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
murder at the hands of party unknown
Shot-with pistol (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) , M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-40131