

N. B.—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.

FILED APR 13 1942

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

10686  
Do not use this space.

1. PLACE OF DEATH

(a) County DOUGLAS Registration District No. 157  
 (b) Township Richland Twp Primary Registration District No. 111 Registered No. 51  
 (c) City Silsam Springs, Mo. (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred 1 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME

Ruben Marion Sorrell  
 (a) Residence, No. Silsam Springs, Mo. St.  (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 26, 1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
79 years 11

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

FATHER 13. NAME ?

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ?

MOTHER 15. MAIDEN NAME ?

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ?

17. INFORMANT (ADDRESS) son Ray Sorrell, Silsam Springs, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Little Zion DATE April 7, 1942

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Russell Barber, Mt. Grove, Mo.

20. FILED \_\_\_\_\_, 19\_\_\_\_ Local Registrar \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 6, 1942

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

I last saw h..... alive on....., 19\_\_\_\_. Death is said to have occurred on the date stated above, at 5 A. M.

The principal cause of death and related causes of importance were as follows:  
 Date of onset

200a

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.  
 (Address) \_\_\_\_\_

RECEIVED

District Health Officer No. 6,

District File Number 442-497

Date Filed APR 10 1942

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**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 .....

Licensed Embalmer No. ....

P. O. Address .....

**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, above space should be left blank.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 10 686

Registration District No. 957

Primary Registration District No. 5396

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Douglas  
(b) City or town Rural  
(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)

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.....

3. (a) PRINT FULL NAME Ruben M. Sorrell

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 Mar 26 1879  
(Month) (Day) (Year)

8. AGE: Years 79 Months - Days - If less than one day..... min.

9. Birthplace..... (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..... (State or foreign country)

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

16. (a) Informant..... (b) Address.....

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

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) 10-1-42 (b) Helma S. Water  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Day.....  
year..... hour..... minute..... M.

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

Due to.....  
Due to.....

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)

(b) 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..... (M. D. or other)

Address..... Date signed.....

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

SUPPLEMENTARY

S-10686 1942