

S. No. 2
M-8-43
5-17-39
P-1 X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38465**

FILED DEC 13 1944

Primary Registration District No. **3048**

Registrar's No. **184**

1. PLACE OF DEATH:

(a) County **NO DAWAY**

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

(c) Name of hospital or institution:
St. Frances Hospital
(If not in hospital or institution, write street number or location) **0**

(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community **11 days**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **Andrew**

(c) City or town **SAVANNAH**
(If outside city or town limits, write "RURAL") **0**

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ **1**

3. (a) PRINT FULL NAME **Malvin Tutterson Sorenson**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **11** day **20**
year **1944** hour **5** minute **A.** M.

21. I hereby certify that I attended the deceased from
1935, 19____, to **11-20**, 19**44**
that I last saw him alive on **11-19**, 19**44**,
and that death occurred on the date and hour stated above.

3. (b) If veteran, name war _____ 3. (c) Social Security No. **499-20-0779**

4. Sex **m** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **M.**

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

7. Birth date of deceased **JAN 15-1910**
(Month) (Day) (Year)

Immediate cause of death
Chc nephritis

8. AGE: Years **34** Months **10** Days **5** If less than one day
hr. _____ min.

Due to **Infection in fractured leg 1933-**

Due to _____

9. Birthplace **Clyde mo**
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) _____

10. Usual occupation **not Employed**

Major findings: Of operations **131**

Of autopsy _____

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

11. Industry or business _____

MOTHER FATHER { 12. Name **Maryon Sorenson** **if**

13. Birthplace **Unknown Denmark**
(City, town, or county) (State or foreign country)

14. Maiden name **Lena Cecelia Jensen**

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

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? _____

16. (a) Informant **Mrs. Lena Sorenson**

(b) Address **Savannah mo**

17. (a) **R.** (b) Date thereof **11-22-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Stanberry**

While at work? _____ (Specify type of place) (e) Means of injury **0**

23. Signature **J. M. Boyle** (M. D. or _____)
Address **Maryville mo** Date signed **11-24-44**

18. (a) Signature of funeral director **E. C. Speit**

(b) Address **Savannah mo**

19. (a) **Nov. 24 44** (b) **Chas. Barker**
(Date received local registrar) (Registrar's signature)

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

74
2

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 E. C. Breit

Licensed Embalmer No. 2650

P. O. Address Lovamahmo

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.