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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37140

FILED DEC 10 1945

Registration District No. 114

Primary Registration District No. 5437

Registrar's No.

1. PLACE OF DEATH:

(a) County Wassonade Co
(b) City or town Red Bird Rural
(If outside city or town limits, write "RURAL" and name of township) Bourbon
(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 1 (Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Wassonade
(c) City or town Red Bird Rural
(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

Pellie M Sorrel

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 21
year 1945 hour 9:50 minute _____ P. M.

21. I hereby certify that I attended the deceased from Nov. 12-1 1945 to November 21, 1945
that I last saw her alive on November 21, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death acute hepatitis Duration 18 days

4. Sex F 5. Color or race Wh 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Rube Sorrel 6. (c) Age of husband or wife if alive 71 years
7. Birth date of deceased 3-28 (Month) (Day) (Year) 1875

8. AGE: Years 70 Months 7 Days 23 If less than one day _____ hr. _____ min.

9. Birthplace Red Bird Mo (City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business _____

MOTHER FATHER { 12. Name Jess. Medley
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name Walt Know
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant Rube Sorrel
(b) Address Bland Mo

17. (a) Burial (b) Date thereof 11-23-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bourbon Can

18. (a) Signature of funeral director W. H. Kessler
(b) Address St James

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

Due to _____

Due to _____

Other conditions Wormlike cast tumor of r. ovary
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 5'00

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? _____

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

23. Signature W. H. Kessler (M. D. or other) 11-23/45
Address _____ Date signed _____

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

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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. 118

Primary Registration District No. 5437

Registrar's No. 146

1. PLACE OF DEATH: Gasconade
 (a) County Gasconade
 (b) City or town Rural - Bourbouis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: sup
(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 Nellie W - Sorel
 3. (b) If veteran, name war.....
 3. (c) Social Security No.....

4. Sex F 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.....

7. Birth date of deceased mar 28
(Month) (Day) (Year)

8. AGE: Years 70 Months 7 Days 2
If less than one day hr. 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.....
 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) Dec. 20-1946 (b) Robert M Murray
(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..... Day.....
 year 1946 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19.....
 that I last 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)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Yes

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

23. Signature..... (M. D. or other).....

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

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

SUPPLEMENTARY

37140