

S. No. 2  
M-5-43  
5-17-39  
I X36871

State File No. \_\_\_\_\_

FILED FEB 25 1947

Registration District No. \_\_\_\_\_

Primary Registration District No. 4187

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County Franklin

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

(c) Name of hospital or institution: Franklin County Infirmary  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 Years (Specify whether years, months or days)

In this community 9 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Franklin

(c) City or town Union  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME John W. Sorrells

3. (b) If veteran, name war No

3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Dora Sorrells

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased May 7 1865  
(Month) (Day) (Year)

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

81 9 45 hr. \_\_\_\_\_ min.

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

10. Usual occupation Farmer

11. Industry or business Farm

MOTHER FATHER

12. Name George Sorrells

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

14. Maiden name Unknown

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

16. (a) Informant County Infirmary

(b) Address Union, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 12/47  
(Month) (Day) (Year)

(c) Place: burial or cremation Buffalo, Sullivan, Mo.

18. (a) Signature of funeral director Wm. P. Stoffer

(b) Address Sullivan, Mo.

19. (a) Feb. 13-1947 (Date received local registrar) (b) J. T. Cooper - ETC (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 11 year 1947 hour 6 minute 30 a.m.

21. I hereby certify that I attended the deceased from 38 to 2-11 1947  
that I last saw h.im alive on 2-10 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Senility

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? Mo.

While at work \_\_\_\_\_ (Specify type of place)

(e) Means of injury Stu

23. Signature Wm. Lenny (M. D. or other) \_\_\_\_\_

Address Union Mo Date signed 2-13-47

RECEIVED  
District Health Officer No. 9,  
District File Number  
Date Filed 2-21-47

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 me

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Robert M Murray

Licensed Embalmer No. 3749

P. O. Address Sullivan, Mo

**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.