

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

XC-1560 949

SL 7898

-61-031131

STATE FILE NUMBER

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED AUG 18 1961

318

1003

7522

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Phelps									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N. Grand, St. Louis, Mo.		Length of stay in 1b 19 days		c. CITY OR TOWN St. James		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET. ADM. HOSPITAL			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) - - - - -		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First ONIA Middle Last SORRELL				4. DATE OF DEATH Month August Day 13 Year 1961									
5. SEX Male		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 11/28/96		9. AGE (last birthday) 64		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country). St. James, Mo.		12. CITIZEN OF WHAT COUNTRY USA					
13a. FATHER'S NAME EDMUND J. SORRELL				13b. MOTHER'S MAIDEN NAME ELSIE BECKHAM				14. NAME OF HUSBAND OR WIFE - - - - -					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-1				16. SOCIAL SECURITY NO.		17. INFORMANT Eva Mitchem (Sister) Address 500 E. Eldon St., St. James, Mo.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TRACHEAL COMPRESSION DUE TO (b) RECURRENT UNDIFFERENTIATED CARCINOMA OF THE THYROID. DUE TO (c) 194x Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown													
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)									
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year													
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE					
21. I attended the deceased from 7/25/61 to 8/13/61 and last saw him alive on 8/13/61 Death occurred at 1:15 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE OF DECEASED (Print name and title) G. W. Mc Roberts, D.D.						22b. ADDRESS VAH, ST. LOUIS, MO.			22c. DATE SIGNED 8/13/61				
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 8-13-61		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) St. James, Mo.		(State)					
24. FUNERAL DIRECTOR Licklider Funeral Home, St. James, Mo.				ADDRESS		25. DATE RECD. BY LOCAL REG. AUG 14 1961		26. REGISTRAR'S SIGNATURE Carl Smith, M.D.					

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 _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *John Bruckley*

Licensed Embalmer No. 3659

P. O. Address *Alameda*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.