

FILED NOV 13 1945

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

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 873

1. PLACE OF DEATH:

(a) County GREENE  
(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
O'Reilly General Hospital, Springfield, Mo  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community 1 month - 11 days  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Minnesota (b) County Dakota  
(c) City or town Lakeville  
(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 HARLAND W. SORENSON

3. (b) If veteran, name war WORLD WAR II 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive XX years  
7. Birth date of deceased July 27, 1924  
(Month) (Day) (Year)

8. AGE: Years 21 Months 2 Days 19 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Northfield Minnesota  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Unknown  
13. Birthplace Unknown (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 O'Reilly Gen. Hosp.  
(b) Address Springfield, Mo

17. (a) Removal (b) Date thereof Oct. 28, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Farmington, Minnesota

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address Springfield, Mo

19. (a) 10-27-45 (b) S. W. S. Handley  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 26  
year 45 hour 9 minute 20 P.M.

21. I hereby certify that I attended the deceased from September 15,  
1945 to October 26 1945;  
that I last saw him alive on 26 October 1945;  
and that death occurred on the date and hour stated above.

Immediate cause of death Toxemia Duration 72 hrs.

Due to Peritonitis, generalized 72 hrs.  
and bronchal pneumonia, bilateral 172 hrs.

Due to Closure of colostomy with leak-  
age 5 days

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations Left pelvic abscess  
Of autopsy Same as above 1946  
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) Accident (Battle casual  
ty  
(b) Date of occurrence 2 July 1945  
(c) Where did injury occur? Cagovan Valley, Luzon, P.I.  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? Yes (Specify type of place) Battle  
(Specify type of place) (e) Means of injury Casualty

23. Signature Silvio Errico (M. D. or other)  
Address SILVIO ERRICO, Capt. M.C. Date signed 10/27/45  
O'Reilly Gen Hosp, Springfield, Mo

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

9  
2  
6

NOV 9 1949

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. 3044

P. O. Address Springfield, 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.

x