

FILED DEC 7 1945
Registration District No. _____

Primary Registration District No. 4215

Registrar's No. 165

1. PLACE OF DEATH:

(a) County Henry
(b) City or town Brownington
(If outside city or town limits, write "RURAL" and name of township)
(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 _____ (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Henry
(c) City or town Brownington
(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 Nov. day 1st
year 1945 hour 7 minute 40 PM
21. I hereby certify that I attended the deceased from Oct. 26th
1945 to Nov. 1st 1945
That I last saw him alive on Nov. 1st 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial asthma Duration 6 days

Due to acute Parenchymatous
Nephritis

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? _____

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

23. Signature E. D. Taylor (M. D. or other) _____
Address Brownington, Mo Date signed 11/1/45

3. (a) PRINT FULL NAME Soren Peter Sorensen

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

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 _____ years

7. Birth date of deceased June 14 1940
(Month) (Day) (Year)

8. AGE: Years 85 Months 7 Days 13 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business

12. Name Unknown
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant Ida P. Shaffer

(b) Address Brownington Mo

17. (a) Buried (b) Date thereof 11-4-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brownington Mo

18. (a) Signature of funeral director C. A. Gickett

(b) Address Brownington Mo

19. (a) Nov - 7 - 45 (b) R. R. Kemmerly
(Date received local registrar) (Registrar's signature)

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

No. 7,

11-45-1168

12-6-45

Date Filed

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 Jim Hurst

Licensed Embalmer No. 2782

P. O. Address Deepwater, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 100Registration District No. 137Primary Registration District No. 4211Registrar's No. 165

1. PLACE OF DEATH:

(a) County Henry
(b) City or town Brownington
(If outside city or town limits, write "RURAL" and name of township)
(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 _____ (Specify whether _____)

In this community _____
years, months or days3. (a) PRINT
FULL NAME Loren P. Edanson3. (b) If veteran,
name war _____3. (c) Social Security
No. _____4. Sex M 5. Color or race W 6. (a) Single, widowed, married,
divorced S6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____7. Birth date of deceased June 14 1946
(Month) (Day) (Year)8. AGE: Years 85 Months 7 Days _____ (If less than one day
hr. _____ min. _____)9. Birthplace Denmark
(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) _____ (b) _____
(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 July
year 1945 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 Chronic Hepatitis Duration _____

Due to _____

Due to Chronic HepatitisOther conditions _____
(Include pregnancy within 3 months of death)ADDITIONAL PHYSICIAN
Major findings: _____
Of operations _____INFORMATION REQUESTED
Of autopsy 13/8Underline
the cause to
which death
should be
charged sta-
tistically.

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

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

Address _____ Date signed 1

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

SUPPLEMENTARY

37343