

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015759

STATE FILE NUMBER

FILED MAY 15 1959

Registration District No.

Primary Registration District No.

Registration No. **4365**

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1-57

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61  
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis (20)</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <b>St. Louis - Little</b> INSTITUTION <b>Rock Hospitals, Inc.</b>			Length of stay in lb <b>33 days</b>	d. STREET ADDRESS <b>6452 Myron Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Burt</b> Middle <b>Joel</b> Last <b>Sorrells</b>				4. DATE OF DEATH Month <b>May</b> Day <b>2</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 13, 1899</b>		9. AGE (In years last birthday) <b>59</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	11. BIRTHPLACE (City and state or country) <b>Roodhouse, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Harvey Sorrells</b>			13b. MOTHER'S MAIDEN NAME <b>Mary Duncan</b>		14. NAME OF HUSBAND OR WIFE <b>Lillian Sorrells</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) <b>yes World War I.</b>		16. SOCIAL SECURITY NO. <b>709-10-9969</b>	17. INFORMANT Address <b>Mrs Lillian Sorrells, 6452 Myron Avenue.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Bronchopneumonia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Two</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Acute Myocardial Infarction</b>				<b>3 wks</b>	
		DUE TO (c) <b>left hemiplegia</b>				<b>3 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Generalized Arteriosclerosis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>	
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.) <b>4201</b>				
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.							
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK		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 <b>3/3/59</b> , to <b>May 2, 1959</b> and last saw <sup>him</sup> <b>live on</b> <b>May 2, 1959</b> Death occurred at <b>4: P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Wm. Kelly MD.</b> (Degree or title)			22b. ADDRESS <b>1755 So Grand</b>			22c. DATE SIGNED <b>5/3/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>May 5, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri.</b>		
24. FUNERAL DIRECTOR <b>Shepard Funeral Home - 1167 Hamilton</b> <b>St. Louis, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>MAY 4 '59</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>		

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 *J. W. Rumbley* .....  
Licensed Embalmer No. *3653* .....  
P. O. Address *St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.