

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 5642

FILED MAR. 10 1947

Primary Registration District No. 5883

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

1. PLACE OF DEATH:

(a) County OSAGE  
(b) City or town Bennets Mill - R.D.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 67 YEARS (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME ELIZABETH-M. HOERSCHGEN

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

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife Jacob Hoerschgen 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased DEC - 8 - 1859  
(Month) (Day) (Year)

8. AGE: Years 87 Months 2 Days 4 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation House wife

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

12. Name ANTONE TROESBER

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

14. Maiden name BARBRA Beck

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

16. (a) Informant Mrs Martha Ruetters  
(b) Address Ann. Mo.

17. (a) Burial (b) Date thereof 2-15-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation HOOPS CREEK

18. (a) Signature of funeral director Clyde Matton

(b) Address Ann. Mo.

19. (a) Feb 23 (b) Mrs Louise Lock  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County OSAGE 76  
(c) City or town Bennets Mill - R.D.  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location) 0  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 0  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 12  
year 1947 hour 9 minute 30 P.M.

21. I hereby certify that I attended the deceased from 2-10-47 to 2-12-47  
that I last saw her alive on 2-12-47  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial failure  
Chronic Bronchitis

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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

Major findings: Of operations \_\_\_\_\_  
Of autopsy 112

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) (c) Means of injury 2  
23. Signature Howard J. Baldwin (M. D. or other) DO  
Address \_\_\_\_\_ Date signed 2-14-47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED  
District Health Officer No. 9,  
District File Number.....  
Date Filed 3-10-47

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

Signed Vernon M. Morton  
Licensed Embalmer No. 4125  
P. O. Address Leam

**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.