

DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI  
BUREAU OF THE CENSUS  
FILED APR 2 1947 STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 53

Registration District No. 116 Primary Registration District No. 2020

1. PLACE OF DEATH:  
(a) County Franklin  
(b) City or town Washington Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Francis Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day  
Specify whether  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Franklin 36  
(c) City or town Rural New Haven, Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME BEN HOERSTKAMP  
3. (b) If veteran, name war X  
3. (c) Social Security No. X

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month March day 24<sup>th</sup>  
year 1947 hour 12:20 minute 7 M.

4. Sex Male 5. Color or race W  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Katy Hoerstkamp  
6. (c) Age of husband or wife if alive 70 years  
7. Birth date of deceased Nov 6 1870  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 21, 1947, to March 24, 1947 that I last saw him alive on March 24, 1947; and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
76 4 18 hr. min.

Immediate cause of death Pronounced Duration  
Due to Epoplyxy  
Due to \_\_\_\_\_

9. Birthplace New Haven Mo  
(City, town, or county) (State or foreign country)  
10. Usual occupation Farmer

Other conditions (Include pregnancy within 3 months of death)  
Major findings: Of operations gpa  
Of autopsy \_\_\_\_\_

MOTHER FATHER  
11. Industry or business Farmer  
12. Name Unknown  
13. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)

PHYSICIAN  
Underline the cause to which death should be charged statistically.

16. (a) Informant St. Francis Hospital  
(b) Address Washington Mo  
17. (a) Burial (b) Date thereof 3/27/47  
(Burial, cremation, or removal) (Monthly) (Day) (Year)  
(c) Place: burial or cremation Catholic Cem. New Haven  
18. (a) Signature of funeral director L. C. Ortega, Son  
(b) Address New Haven Mo  
19. (a) 3/24/47 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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 L. P. Fox (M. D. or other) \_\_\_\_\_  
Address Washington, Missouri Date signed 3/24/47

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

RECEIVED  
District Health Officer No. 9,  
District File Number  
Date Filed 4-1-47

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 Earl Fertig  
Licensed Embalmer No. 3385  
P. O. Address. New Haven 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.