

S. No. 2  
M-5-43  
5-17-39  
X36671

FILED APR 18 1947

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

Registration District No. 240

Primary Registration District No. 4358

Registrar's No. 46

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

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town Lilbourn  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Home  
(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 (Specify whether \_\_\_\_\_)

3. (a) PRINT FULL NAME William Weston Hoehn

3. (b) If veteran, name war No.

3. (c) Social Security No. 490-28-5550

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Anna Hoehn

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased August 26 1877  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

69 7 13 hr. \_\_\_\_\_ min.

9. Birthplace New Madrid, Missouri.  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Carpenter

11. Industry or business

12. Name Peter Hoehn

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

14. Maiden name Jennie White.

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

16. (a) Informant Anna Hoehn

(b) Address Lilbourn, Missouri

17. (a) Burial (b) Date thereof 4-11-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Evergreen, New Madrid

18. (a) Signature of funeral director Ponder Funeral Home

(b) Address Lilbourn, Missouri.

19. (a) 4-11-47 (b) H. S. Ponder Deputy  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid

(c) City or town Lilbourn.  
(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 April day 9  
year 1947 hour 5 minute P.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;  
Not attended.

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Probably nitral regurgitation

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

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

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

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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. E. Jones (M. D. or other) \_\_\_\_\_

Address Lilbourn, Mo Date signed 4-11-47

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

218

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**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 Donner L Ponder

Licensed Embalmer No. 3367

P. O. Address Lillooie, Missouri

**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.**