

FILED DEC 2 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 29399BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 2832

1. PLACE OF DEATH a. COUNTY <u>St. Louis County</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis County</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Ferdinand (Rural)</u>		c. LENGTH OF STAY (In this place) <u>38 yrs</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Ferdinand (Rural)</u>		d. STREET ADDRESS (If rural, give location) <u>RR # 3 Box 301 4000</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>RR # 3 Box 301</u>					

3. NAME OF DECEASED a. (First) <u>Josephine</u> b. (Middle) <u>Gertrude</u> c. (Last) <u>Hoorman</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 23 1950</u>		
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5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>25 April 1882</u>	9. AGE (In years last birthday) <u>68</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>21</u>	IF UNDER 1 MRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>St Paul, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
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13a. FATHER'S NAME <u>Henry Karsting</u>		13b. MOTHER'S MAIDEN NAME <u>Gertrude Foeller</u>		14. NAME OF HUSBAND OR WIFE <u>Bernard C Hoorman</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Bernard C. Hoorman</u> ADDRESS <u>RR # 3 Box 301</u>	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		DUE TO (b) <u>Arteriosclerosis</u>				<u>29 Days</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) _____					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>Hypostatic Pneumonia</u>				<u>331X</u>	

19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	

22. I hereby certify that I attended the deceased from 15 Sept, 1950, to 23 Nov, 1950, that I last saw the deceased alive on 23 Nov, 1950, and that death occurred at 9:35 m., from the causes and on the date stated above.

23a. SIGNATURE <u>Marion D. Bishop MD</u> (Degree or title)		23b. ADDRESS <u>409 Jean Ave Ferguson Mo</u>		23c. DATE SIGNED <u>23 Nov 50</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>11/27/50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Ferdinand Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Florissant, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>11/24/50</u>	REGISTRAR'S SIGNATURE <u>Herbert P. Dombke MD</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>White Chapel, Ferguson, Mo.</u>	ADDRESS _____
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

working under my personal supervision.

Student Embalmer No.

Signed

L. M. Shulte

Signed.....

Student Embalmer

Licensed Embalmer No. *3973*

P. O. Address *Perquimans, N.C.*

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.