

Health, Welfare & Public Service
 2361
 300
 1-57
 All diseases in Part I must be causally related.
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

FILED FEB 25 1958

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

58-005015

STATE FILE NUMBER

Registration District No. 114 Primary Registration District No. 4186 Registrar's No. 11

1. PLACE OF DEATH a. COUNTY <u>FRANKLIN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>FRANKLIN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SULLIVAN MERAMEC</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>MORRETTON</u> <u>034</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>NORTHSIDE HOSP.</u>		Length of stay in lb <u>1 DAY</u>	d. STREET ADDRESS (If outside, give location) <u>RURAL</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>SOPHIE E. BENSCHING</u>			4. DATE OF DEATH Month Day Year <u>FEB 21 1958</u>			
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 21, 1892</u>	9. AGE (In years last birthday) <u>76</u>	IF UNDER 1 YEAR Months Days Hours Min. <u>2 0</u>	IF UNDER 24 HRS.
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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>HOUSEWIFE</u>	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS, MO.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>PETER VAN HOTEGEN</u>	13b. MOTHER'S MAIDEN NAME <u>EMILY VANDE VOORTRE</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) (If yes, give war or dates of service) <u>NONE</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>LOUISE HOEFER</u> <u>2616</u> Address <u>KINGS HIGHWAY ST. LOUIS, MO.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>YEARS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) <u>4500</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>THROMBOSIS DEEP ARTERY RIGHT FOOT</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
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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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <u>FEB 20-58</u> , to <u>FEB 21-58</u> and last saw ^{her} _{him} alive on <u>FEB 20-1958</u> Death occurred at <u>3:00 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>Robert M. Crawford M.D.</u>	22b. ADDRESS <u>Sullivan Mo.</u>	22c. DATE SIGNED <u>Feb 21-58</u>
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23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>2/24/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MOUNT OLIVE CEM.</u>	23d. LOCATION (City, town, or country) (State) <u>ST. LOUIS, MO.</u>
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24. FUNERAL DIRECTOR <u>Sherwood W. Kitchell</u>	ADDRESS <u>St. Clair, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>2-22-58</u>	26. REGISTRAR'S SIGNATURE <u>Thomas A. Dempsey</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION

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 *Sherwood W. Kitchell*

Licensed Embalmer No. *3873*
P. O. Address *H. Clair, Ind*

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.