N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

3036

1 PLACE OF DEATH

County St Louis.

Township CARONDELET

or

Village

or

City (NO. 111 Eight St. St.; Ward)

Registration District No. 23 File No.

Primary Registration District No. 2 4 8 A. Registered No. 42

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Joseph Hoffmann

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Aug (Month) 21 (Day) 1876 (Year)

7 AGE 42 yrs. 5 mos. 4 ds. If LESS 1 day, ... or ... min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Beer Bottler

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country) St Louis, Mo.

PARENTS

10 NAME OF FATHER. Michael Hoffmann

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) St Louis, Mo

12 MAIDEN NAME OF MOTHER Catherine Ertel

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) St Louis Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anna Hoffmann

(Address) 111 Eight

15 Filed JAN 27 1919, 191 L. C. Obrock Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan (Month) 25 (Day) 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 1, 1918, to Jan 25, 1919 that I last saw him alive on Jan 25, 1919 and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

23A

28

(Duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) A W Peters M. D.

Jan 26 1919 (Address) 8208 Alabama

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ... yrs. ... mos. ... ds. In the State ✓ yrs. ... mos. ... ds.

Where was disease contracted if not at place of death? ✓

Former or usual residence ✓

19 PLACE OF BURIAL OR REMOVAL ~~Mt Olive~~ S. S. Peter & Paul DATE OF BURIAL Jan 28, 1919

20 UNDERTAKER Clem W Eick ADDRESS 412 Duchouquet Ave

V. S. No. 2.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....Wa

2. FULL NAME.....

(a) Residence. No..... St. .....Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19
that I last saw h..... alive on....., 19....., an
death occured, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....(duration).....yrs. .....mos.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed).....
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDA HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURI
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.