

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

Do not use this space

33476

791

1003

1. PLACE OF DEATH

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City St. Louis, Mo. (No. 4042)

Missouri

File No.....

Registered No. 10157

10157

2. FULL NAME William Hoffmann

(a) Residence. No. 4042 Missouri St. 15 Ward.

Length of residence in city or town where death occurred

yrs.

mos.

da.

How long in U.S., if of foreign birth?

yrs.

mos.

da.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

Francis Hoffmann

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 12 1861

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

65

9

13

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cabinet maker

(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)

Germany

10. NAME OF FATHER

Levir Knob

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

12. MAIDEN NAME OF MOTHER

Levir Knob

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

14.

INFORMANT

(Address)

Mr Francis Hoffmann

FILED

19

OCT 27 1926

Marl Starck

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Oct 25 1926

17.

I HEREBY CERTIFY, That I attended deceased from Oct 20th, 1926, to Oct 25th, 1926 that I last saw h. live on Oct 25th, 1926, and that death occurred, on the date stated above, at 10 21 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

131 Dysentery
132
 (duration)..... yrs..... mos. 1 1/2
 CONTRIBUTORY Chronic Intestinal Nephritis
 (SECONDARY)
 (duration)..... yrs..... mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH

WAS THERE AN ANOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS

(Signed).....

Chas E F Straiker

M. D.

Oct. 26, 1926 (Address) 3860 S Broadway

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

New St Marcus Cem

10-28 1926

20. UNDERTAKER

ADDRESS

Weick Bros 2201

Ro Grand

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.

