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

Do not use this space.

32142

File No. 9524

Registered No.

1. PLACE OF DEATH

County

Registration District No. 791

Township

Primary Registration District No. 1003

City St Louis Mo (No. 5347, Perry Ave St. Ward)

2. FULL NAME Laura Hoffman

(a) Residence. No. St., 6 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. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

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

5a. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) ~~WIFE OF~~ August Hoffman

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 23rd 1868

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	10	1	

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

82A 97

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

PARENTS

10. NAME OF FATHER John Kessler

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

12. MAIDEN NAME OF MOTHER Mary Greenaugh

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

14. INFORMANT Mrs Margaret Sherry
(Address) 5347 Perry Ave

15. FILED OCT 25 1927 Marie Starkoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 24th 1927

17. I HEREBY CERTIFY, That I attended deceased from August 1927 to October 24th 1927 that I last saw h. alive on October 24th 1927, and that death occurred, on the date stated above, at 4.40 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Haemorrhage
Apoplexy (duration) yrs. 25 mos. ds.

CONTRIBUTORY (SECONDARY) Arterio - Sclerosis (duration) 6 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. F. Gallagher, M. D.
10/25, 1927 (Address) 311-318 Wall Bldg

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Calvary — DATE OF BURIAL Oct 27 1927

20. UNDERTAKER Math Hermann & Son — ADDRESS 4103 Florissant

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.

WRITE PLAINLY, WITH INFADING INK—THIS IS A PERMANENT RECORD