

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

Do not use this space.

35076

**1. PLACE OF DEATH**

County.....

Registration District No.....

791

1003

File No.....

10225

Township.....

Primary Registration District No.....

Registered No.....

St. .... Ward)

City.....

**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 5 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

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

Female White Married

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

Robert Hoffman

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

March 4, 1847

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ...hra. or ...min.

80 8 11

**8. OCCUPATION OF DECEASED**

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

Housewife

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

at home

(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY)

Iowa

**10. NAME OF FATHER**

Geo. Ocher

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Germany

**12. MAIDEN NAME OF MOTHER**

Winters

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Germany

**14. INFORMANT**

(Address)

at home city / hospital

**15. FILED**

NOV 15 1927

may 6 Starkeoff

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

Nov 15 1927

17.

I HEREBY CERTIFY That I attended deceased from Nov 9, 1927 to Nov 15, 1927 that I last saw h. .... alive on Nov 15, 1927 and that death occurred, on the date stated above, at 1:30 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Chronic interstitial nephritis  
Chronic myocarditis 131

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

arterio-sclerosis; Senility

(duration) yrs. mos. ds.

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) Edmund R. Sherida, M. D.

, 1927

Address) city / hospital

\*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

DATE OF BURIAL

Fort Madison, Iowa

Nov 16 1927

20. UNDERTAKER

Geo. L. Peitoch

ADDRESS

59 66  
Boston

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.

Hoffman