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

Do not use this space.

32048

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 9309

City St. Louis, Mo. (No. 5600 Arsenal St. 24th Ward)

2. FULL NAME Frank Hoffman

(a) Residence. No. 2011 N. Broadway St., 26 Ward. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 8 mos. 7 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 12-23-1927

7. AGE: Years 0 | Months 8 | Days 24 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: nil
(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): ~~(Mo)~~ St. Louis Mo

PARENTS

10. NAME OF FATHER: Frank Hoffman
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): St. Louis Mo.
12. MAIDEN NAME OF MOTHER: Blanche Tom
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Penn.

14. INFORMANT: Tom Hoffman (Address) 2011 N. Broadway

15. FILED SEP 18 1928, 19.. Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Sept 17 1928

17. I HEREBY CERTIFY, That I attended deceased from Sept. 14, 1928, to Sept 17, 1928 that I last saw him alive on Sept 17, 1928, and that death occurred, on the date stated above, at 4:55 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Typhoid Fever

(duration) 0 yrs. 0 mos. 11 ds.

CONTRIBUTORY (SECONDARY) .....

(duration) 0 yrs. 0 mos. 0 ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 2011 N. Broadway

DID AN OPERATION PRECEDE DEATH? NO. DATE OF .....

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Laboratory

(Signed) George H. Garrison, M.D.

9/17, 1928 (Address) ISOLATION 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: Calvary Cem. DATE OF BURIAL: Sept 19th 1928

20. UNDERTAKER: Edward Koch ADDRESS: 3516 414th

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 UNFADING INK—THIS IS A PERMANENT RECORD