

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

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PLACE OF DEATH

County St. Louis Registration District No. 789
 Township Central Primary Registration District No. 6093 B. File No. _____
 City St. Louis (Name) Central Sanatorium St. _____ Ward _____
 Registered No. 89

2. FULL NAME

Bessie Hoffman
 (a) Residence No. 45-69 Page St. 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. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 66

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
66

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
St. Louis
Russia

10. NAME OF FATHER Samuel Ostrowsky

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT N. Hoffman
 (Address) 4569 Page St.

15. FILED 3/14 1929 Willa Gray REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-14-1929

17. I HEREBY CERTIFY, That I attended deceased from Jan - 24 - 1929, to Mar - 14 - 1929 that I last saw her alive on Mar - 13 - 1929, and that death occurred, on the date stated above, at 5-9 - m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Removal of Gallbladder
ABC
 (duration) 8 yrs. 2 mos. 13 ds.

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: St. Louis

DID AN OPERATION PRECEDE DEATH: _____ DATE OF _____
 WAS THERE AN AUTOPSY? none

WHAT TEST CONFIRMED DIAGNOSIS: Clinical
 (Signed) Georg Simons, M. D.
3/14, 1929 (Address) Lehigh Park

*State the DISEASE CAUSING DEATH or in deaths from VIOLENCE CAUSING state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Chesed Shel Emeth DATE OF BURIAL 3-14-1929

20. UNDERTAKER N. B. Berger ADDRESS 1215 N. Pearson

235
23
23
23

Witcher

11

12

13

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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St. Louis Registration District No. 789 File No.
Township Central Primary Registration District No. 6033B Registered No. 89
City (No., St. Ward)

2. FULL NAME Bessie Hoffman

(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. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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)

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 3/14 1929 Golla Braep M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/14 1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tumor of Spleen
Malignant
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) (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)....., M. D.
, 19 (Address)

*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
19

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

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

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION as prescribed by LAW

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