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

Do not use this space.

12691

1. PLACE OF DEATH

County ..... Registration District No. 797 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 5226

City St Louis (No. 3831a Ashland ..... St. ..... Ward)

2. FULL NAME Carrie F Hoffmann

(a) Residence. No. ..... St., 10 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: William Hoffmann

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Nov 26 1859

7. AGE: Years 69 | Months 3 | Days 15 | If LESS than 1 day, ... hrs. or ..... min.

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): Illinois

PARENTS

10. NAME OF FATHER: William Mears
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY): Illinois
12. MAIDEN NAME OF MOTHER: Amy Gann
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY): Illinois

14. INFORMANT: Mrs T. J. Sullivan
(Address) 3831a Ashland

15. FILED 11 1929 Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Mar 13 — 1929

17. I HEREBY CERTIFY, That I attended deceased from Mar 5, 1929, to Mar 11, 1929, that I last saw her alive on Mar 4, 1929, and that death occurred, on the date stated above, at 6 A.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

107 A

Bronchial Pneumonia

Acute (duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... 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. L. Marder, M. D.

, 19 (Address) 2806 N. Grand Blvd St Louis Mo

*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: Mch 15 1929

20. UNDERTAKER: Hanigan Sheahan Mo

ADDRESS: 4415 Washington

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.

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