

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis,**

(No. **3830 Indiana Avenue.**)

File No. **25849**

Registered No. **7020**

St. _____ Ward _____

2. FULL NAME William Hoffmann.

(a) Residence. No. **3830 Indiana Avenue.** St. **24** Ward.

(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

Male

4. COLOR OR RACE

White

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

Married

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

Anna Hoffmann.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Nov. 2, 1877.**

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

51

7

29.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. **Japanner.**

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

(c) Name of employer **Century Electric Co.**

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

10. NAME OF FATHER **Dont Know.**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Dont Know.**

12. MAIDEN NAME OF MOTHER **Dont Know.**

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

14. INFORMANT Mrs. Anna Hoffmann
(Address) **3830 Indiana Avenue.**

15. FILED 19..... Max C. Stankel
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **July 1 1929**

17. I HEREBY CERTIFY, That I attended deceased from June 12, 1929, to July 1st, 1929 that I last saw him alive on July 1st, 1929, and that death occurred, on the date stated above, at 10 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Myocarditis

CONTRIBUTORY (SECONDARY) **Acute Cholecystitis** (duration) yrs. mos. **1** ds.

(duration) yrs. mos. **14** 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 **physical, clinical and laboratory find-**
(Signed) [Signature] M. D.

7/1/1929 (Address) **3608 S. Grand Blvd.**

*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 **July 4, 1929.**
Funeral - Burial

20. UNDERTAKER **ADDRESS** **842 Meramec.**
J. H. Hubbard & Co.

WRITE CLEARLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

69
37

