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

Do not use this space.

30508

1. PLACE OF DEATH

County ..... Registration District No. 303 ..... File No. .....

Township ..... Primary Registration District No. 4182 ..... Registered No. .....

City Hermann (No. ..... St. ..... Ward)

2. FULL NAME Wm C. Hoffmann Sr

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 6-1852

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
77	3	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Shoe Worker.
(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) Germany

PARENTS

10. NAME OF FATHER Johan Hoffman
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Leimhalm
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Germany.

14. INFORMANT Mrs. Hy. Heinlein
(Address)

15. FILED 9-28, 1929 Anna K Rickhoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 26 1929

17. I HEREBY CERTIFY, That I attended deceased from Sept 10, 1929, to Sept 26, 1929 that I last saw him alive on Sept 26, 1929, and that death occurred, on the date stated above, at 9.15 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Aneurysm of arch of aorta

..... (duration) 2 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) F. H. Caughill, M. D

, 19 (Address) Herman 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: Hermann City Cemetary — DATE OF BURIAL: 9/29 1929

20. UNDERTAKER: E Rudiger — ADDRESS: Herman Mo