FEB 18 1930

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

Do not use this space.
Feller

File No. 832
Registered No. 80

1. PLACE OF DEATH
County: Greene
Registration District No.: 318
Township:
Primary Registration District No.: 2001
City: Springfield (No. 1101 W. Thoman St. St. Ward)

2. FULL NAME: Gloria E. Hoffman
(a) Residence. No. 1101 W Thoman 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: 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: ✓

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Feb 5 - 1856

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73	11	23	

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): Indiana

PARENTS
10. NAME OF FATHER: Abram Line
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY): Ohio
12. MAIDEN NAME OF MOTHER: Delia Russell
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY): Ohio

14. INFORMANT: J. N. Line
(Address): Springfield, Mo.

15. FILED 1-28, 1930 Lon Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 1-28- 1930

17. I HEREBY CERTIFY, That I attended deceased from 1-25- 1930, to 1-28 1930, that I last saw her alive on 1-27- 1930, and that death occurred, on the date stated above, at 1 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
798
162
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Senility
(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) C. E. Feller, M. D.
1-28, 1930 (Address) Springfield 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	DATE OF BURIAL
Spring Valley Minn	Jan 30 1930
20. UNDERTAKER 424 E. Commercial St	ADDRESS
J. W. Klingner & Co.	Springfield, Mo.

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.

16