

**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. **7 791**

Township.....

Primary Registration District No. **1003**

City **St. Louis Mo.** (No. **4144**) **Beethoven**

File No. **14215**

Registered No. **3550**

St. Ward)

2. FULL NAME

Elsie Hofmeister

(a) Residence. No. **4144 Beethoven** St., **15** 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) married	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Steven Hofmeister					
6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 22 - 1887					
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.	
	42	10	16		
8. OCCUPATION OF DECEASED					
(a) Trade, profession, or particular kind of work Housewife					
(b) General nature of industry, business, or establishment in which employed (or employer).....					
(c) Name of employer.....					

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

PARENTS	10. NAME OF FATHER G. F. Alexander
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Francis Co. (STATE OR COUNTRY) Mo
	12. MAIDEN NAME OF MOTHER Mathilda Bone
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Francis Co. (STATE OR COUNTRY) Missouri	

14. INFORMANT **Steven Hofmeister** (Address) **4144 Beethoven**

15. REGISTERAR **W. E. Stanley**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **4-8** 19**30**

17. I HEREBY CERTIFY, That I attended deceased from **4-7-1930**, to **4-8-1930** that I last saw h..... alive on **4-8-1930** and that death occurred, on the date stated above, at **6:20 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
92A (apoplexy)
107A (duration) **sudden** yrs. mos. da.

CONTRIBUTORY **Broncho-Pneumonia** (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED **7441** IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? **No** DATE OF..... WAS THERE AN AUTOPSY? **No** WHAT TEST CONFIRMED DIAGNOSIS? **Physical finding** (Signed) **Joseph Backler** M. D.

4/8, 1930 (Address) **4602 Greaves**
*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 **Lakewood Park Cem** DATE OF BURIAL **4-10 1930**

20. UNDERTAKER **Weick Bros 2201 So Grand Blvd** ADDRESS

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.

FILED **9-1930**

