

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

Do not use this space.

14335

1. PLACE OF DEATH

County St. Louis Registration District No. 791
 Township St. Louis Primary Registration District No. 791
 City St. Louis St. 20 Ward 20

File No. _____
 Registered No. 3671
 St. _____ Ward _____

2. FULL NAME

Matilda Hoffman
 (a) Residence No. 2209 Herbert St. St. 20 Ward 20
 (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 single
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 18th 1865

7. AGE 66 YEARS 11 MONTHS 25 DAYS
 IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) housekeeper 2341
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Germany 15

PARENTS

10. NAME OF FATHER William Hoffman

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Austria 51

14.

INFORMANT Sister Jeanne
 (Address) 2209 Herbert St.

15.

FILED 19 1932 May 13 1932 St. Louis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 13th 1932

17. I HEREBY CERTIFY, That I attended deceased from April 2, 1932 to April 13, 1932 that I last saw him alive on April 12, 1932 and that death occurred, on the date stated above, at 12 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

93c Bronchopneumonia
1070 (duration) yrs. mos. 11 ds.

CONTRIBUTORY (SECONDARY) Chronic Myocarditis
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 13 1

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical Examination

(Signed) Anthony A. Bruckner M. D.

4/17, 1932 (Address) 1525 a Cass Ave

*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

St. Matthews Apr 16 1932
 20. UNDERTAKER St. Matthews ADDRESS 1535 1/2 Ward

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.

