

WRITE PLAINLY, 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.

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

Do not use this space.
✓ 33955
File No. _____
Registered No. **9300**
St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. _____
Township _____ Primary Registration District No. _____
City *St. Louis Mo.* (No. *3119 Aeshubk St.*)

2. FULL NAME

William F. Hoffer
(a) Residence, No. *3119 Aeshubk St.* St. *16* 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 _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *May 31-1861*

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<i>71</i>	<i>4</i>	<i>19</i>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Police officer*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Louisiana 2*

13. NAME *George Hoffer*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Pennsylvania*

15. MAIDEN NAME *Unknown*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown 31*

17. INFORMANT *Magdalena Hoffer* (ADDRESS) *3919 Aeshubk St.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Sunset Blvd St.* DATE *Oct. 21-1932*

19. UNDERTAKER *Jegenbaum Bros.* (ADDRESS) *2525 Aeshubk St.*

20. FILED *50702119* _____ (Address) _____ Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Oct. 18-th* 19 *32*

22. I HEREBY CERTIFY, That I attended deceased from *August 1, 1932* to *Oct 18-th* 19 *32*

I last saw h. *alive* on *17*, 19 *32* Death is said to have occurred on the date stated above, at *10:0 a. m.*

The principal cause of death and related causes of importance were as follows:

Arterio Sclerosis
Coronary Hypertrophy
Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____ (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____ (Signed) *D. F. Woodruff*, M. D.

(Address) *3109 Grand Blvd*

