JAN 26 1934

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

Do not use this space.

39381

1. PLACE OF DEATH
16 County Cape Girardeau — Registration District No. 124 — File No.
Township Byrd — Primary Registration District No. 4070 — Registered No. 50
City Jackson, Mo. (No. ..... St. ..... Ward)

2. FULL NAME Louis C. Hoffmeister

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	W	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 23-1867

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
66	9	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Traveling Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Cape Girardeau
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Christian Hoffmeister
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Johanna Wolters
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany
(STATE OR COUNTRY)

14. INFORMANT Mrs L. C. Hoffmeister
(Address) Jackson, Mo.

15. FILED 12-16, 1933 D. G. Tribus REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-15 1933

17. I HEREBY CERTIFY, That I attended deceased from 12-12, 1933 to 12-15, 1933 that I last saw him alive on 12-15, 1933, and that death occurred, on the date stated above, at 1.15 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 2 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) C. R. Schoen, M. D.

12-16, 1933 (Address) Jackson 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
Russell Heights	12/17 1933
20. UNDERTAKER	ADDRESS
McCombs Furnished Co.	Jackson, Mo.

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.