

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.

SEP 25 1935

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

Do not use this space.

27549

1. PLACE OF DEATH

County... St. Louis Registration District No. 790  
Township... Clayton Primary Registration District No. 6032a  
City... St. Louis (No. St. Louis County)

File No. 27549  
Registered No. 245  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

Mabel Hoefling (Hoefling)  
(a) Residence, No. 128 E. Riga Longwood Ward \_\_\_\_\_  
(Usual place of abode)

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. (If nonresident, give city or town and State)

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 Adam Hoefling

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4-11-1895

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, or, ..... hrs. or, ..... min.
<u>40</u>		<u>4</u>	<u>20</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. h.s.w.k.  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. at home  
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) St. Louis, Mo.

13. NAME Chas. Kauffman

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

15. MAIDEN NAME Helen (Unknown)

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

17. INFORMANT Adam Hoefling  
(ADDRESS) 128 E Riga

18. BURIAL, CREMATION OR REMOVAL PLACE Kathalla DATE 9-4-35

19. UNDERTAKER Southern Und. Co.  
(ADDRESS) 6322 S Grand

20. FILED 9/3 1935 Dea J. J. Quaselle  
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-31-1935

22. I HEREBY CERTIFY, That I attended deceased from Aug 28, 1935, to Aug 31, 1935  
I last saw her alive on 8-31-35 4:00 PM, 1935. Death is said to have occurred on the date stated above, at 10:15 P.M.  
The principal cause of death and related causes of importance were as follows:

Degenerative Heart Disease  
Ischemic Heart Disease  
Chr. Myocarditis  
(Leukos)  
Other contributory causes of importance: Pneumonia  
Syphilis

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? yes

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? No.  
If so, specify \_\_\_\_\_  
(Signed) J. J. Quaselle M. D.  
(Address) 128 E Riga

OCCUPATION  
MOTHER  
FATHER

69 31

