

DEC 20 1937

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

Do not use this space.

40326

1. PLACE OF DEATH

County Jackson
Township Jackson
City Kansas City (No. 2C Gen Hosp)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 4840
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 11970 Walnut Ward _____
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w. 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) April 12 1894

7. AGE YEARS 43 MONTHS 7 DAYS 4 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. none

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) Iowa13. NAME Gus Hoffman14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany15. MAIDEN NAME Mary Gaylord16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany17. INFORMANT (ADDRESS) Reverend Clerk Gen Hosp18. BURIAL, CREMATION, OR REMOVAL PLACE Remains in home DATE Nov-19-3719. UNDERTAKER (ADDRESS) Mrs. C. F. Guster 418 Broadway, N. C. 20020. FILED Nov. 17, 37 M. M. Brown Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-16 193722. I HEREBY CERTIFY, That I attended deceased from 11-9, 1937, to 11-16, 1937I last saw him alive on 11-16, 1937 Death is saidto have occurred on the date stated above, at 5:25 am

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

Bilateral Pulmonary Date of onsettuberculosis23

Other contributory causes of importance:

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? _____

If so, specify _____

(Signed) P. J. De Maria, M. D.(Address) 2C Gen Hosp

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.

A.M.

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FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

40326
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1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township..... Primary Registration District No. 1002 Registered No. 4640
 (c) City R. C. (d) Street No.....
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Albert Hoffman
 (a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED M
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Pearl Hoffman
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
 7. AGE YEARS 43 MONTHS 7 DAYS 4 If LESS than 1 day, hrs. or min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as 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)

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19.....

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Nov 17, 1937 M. M. Crume Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-16-37

22. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....

I last saw h..... alive....., 19..... Death is said to have occurred on the date stated above, at..... m.

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

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) P. J. Demario, M. D.

(Address) Sup. Gen. Hosp. R. C.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 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.

