

OCT 20 1938

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

Dr. Robert Williams  
32244  
Do not use this space.

1. PLACE OF DEATH

(a) County Greene Registration District No. 316  
(b) Township W Primary Registration District No. 2001  
(c) City Springfield, Mo. (d) Street No. 781 W. Walnut Registered No. 736  
(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

(a) Residence, No. 781 W. Walnut 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

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 29 1938

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

22. I HEREBY CERTIFY, That I attended deceased from June 37 to Sept 29, 1938  
I first saw him alive on Sept 29, 1938. Death is said to have occurred on the date stated above, at 11:05 P.M.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 12 1848  
7. AGE YEARS 90 MONTHS 1 DAYS 17  
If LESS than 1 day, hrs. or min.

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

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired  
9. Industry or business in which work was done, as saw mill, bank, etc. Merchant  
10. Date deceased last worked at this occupation (month and year) 1938  
11. Total time (years) spent in this occupation 1

Valvular Heart Disease  
Date of onset None known

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Shoal Creek, Illinois

Other contributory causes of importance: Age

FATHER 13. NAME James D. Hoffman

Name of operation None Date of None

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

What test confirmed diagnosis? None Was there an autopsy? None

MOTHER 15. MAIDEN NAME Eliza Crispin

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? None Date of injury None, 1938  
Where did injury occur? None (Specify city or town, county, and State)

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

Specify whether injury occurred in Industry, in home, or in public place.

17. INFORMANT (ADDRESS) Mrs. Eva Hoffman, Springfield, Mo.

Manner of injury None  
Nature of injury None

18. BURIAL, CREMATION, OR REMOVAL PLACE Highland DATE Oct 1 1938

24. Was disease or injury in any way related to occupation of deceased? no  
If so, specify None

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Alvin L. Meyer, Springfield, Mo.

(Signed) Robert Williams, M. D.  
(Address) Springfield, Mo.

20. FILED Oct 11 1938 Chas. A. George Local Registrar

Every item of information should be carefully supplied. Nothing 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.

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, .....

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**