

350 JUL 12 1933

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

20983
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. **791**
 (b) Township..... Primary Registration District No. **1003**
 (c) City St. Louis (d) Street No. Missouri Baptist Sanitarium St.
 (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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME **155 Sarah E. Hofmann.**

(a) Residence, No. St. Agnes Home St. **VR** Kirkwood, Mo.
 (Usual place of abode, if no street address, write county or city) (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) widow		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Chas. E. Hofmann				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1848-1-7				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	91	5	23	
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At home			
	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) Dublin, Ind.				
FATHER	13. NAME Jos. Goodneau			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Scotland			
MOTHER	15. MAIDEN NAME Elizabeth Cornwell			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) England			
17. INFORMANT Mrs. Nettie H. Gildehaus (ADDRESS) Parkview Hotel				
18. BURIAL, CREMATION, OR REMOVAL PLACE Bellefontaine DATE 7/1/39 , 19 39				
19. FUNERAL DIRECTOR (NAME) Robert J. Ambruster (ADDRESS) Clayton Rd. at Concordia Lane				
20. FILED JUN 30 1939 J. F. Breda Local Registrar				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **June 30, 1939**

22. I HEREBY CERTIFY, That I attended deceased from **March 1, 1939** to **June 30, 1939**
 I last saw her alive on **June 29, 1939** Death is said to have occurred on the date stated above, at **7:45 A.**
 The principal cause of death and related causes of importance were as follows:
Coronary occlusions
 Date of onset

Other contributory causes of importance:
Senility

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? **NO**

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) **Arthur M. Thompson**, M. D.
 (Address) **Mo. Theater Bldg.**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

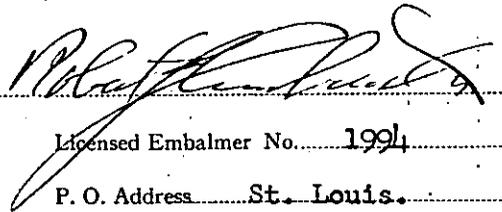
K. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1 X1695

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..... 1994

P. O. Address..... St. Louis.....

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.