

791 STANDARD CERTIFICATE OF DEATH

State File No. 539  
Registrar's No. 539

Registration District No. 1008 Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH

(a) County St. Louis  
(b) City or town St. Louis  
(c) Name of hospital or institution: St. Louis City Hospital  
(d) Length of stay: In hospital or institution 3 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis  
(c) City or town St. Louis  
(d) Street No. No Home  
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME Louis J. Hoffman

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Unknown (Month) (Day) (Year)

8. AGE: 65 Years Months Days If less than one day hr. min.

9. Birthplace Greece (City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business \_\_\_\_\_

12. Name of father Centurion

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace St. Louis (City, town, or county) (State or foreign country)

16. (a) Informant Louis Short (b) Address 4505 Rosa

17. (a) Burial (b) Date thereof 1-19-40 (c) Place: burial or cremation St. Matthews

18. (a) Signature of funeral director Albert H. Weger (b) Address 16700 Washington Ave.

19. (a) JAN 19 1940 (b) J. J. Brundick (Date received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 13 year 1940 hour 8 minute 30 A.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death: Cedema of Brain  
Due to Chronic Myocarditis  
Due to Emphysema of Lungs  
Other conditions: None  
Major findings: Cystic Kidney  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury None

23. Signature Joseph M. Quinn (M. D. or other) \_\_\_\_\_  
Address Deputy Coroner Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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 *Albert G. Hoffa*.....

Licensed Embalmer No. *2991*.....

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.**