

APR 12 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9548

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 982

1. PLACE OF DEATH: K Jackson
 (a) County K Jackson
 (b) City or town Kansas City
 (c) Name of hospital or institution: In-K. S. Hosp. Kensington
 (d) Length of stay: In hospital or institution 25 yrs (Specify whether In this community years, months or days)

3. (a) PRINT FULL NAME Madeline Hoffman
 3. (b) If veteran, name war ✓
 3. (c) Social Security No. 158

4. Sex Fe 5. Color or race Wh
 6. (a) Single, widowed, married, divorced Widow
 6. (b) Name of husband or wife August Hoffman
 6. (c) Age of husband or wife if alive 26 years
 7. Birth date of deceased Oct 26 1859 (Month) (Day) (Year)

8. AGE: Years 81 Months 4 Days 5
 If less than one day hr. min.

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

10. Usual occupation At home

11. Industry or business
 MOTHER { 12. Name August Krissel
 13. Birthplace Germany (City, town, or county) (State or foreign country)
 FATHER { 14. Maiden name Bergetta Blau
 15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Louise Coakley
 (b) Address 806 Kensington

17. (a) Burial (b) Date thereof 3/5/40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation mt st marys

18. (a) Signature of funeral director Carroll Davidson
 (b) Address 3025-40 30 254 Frost

19. (a) (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City
 (d) Street No. 806 Kensington
 (e) If foreign born, how long in U. S. A. 68 years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month March day 1st
 year 1940 hour 8 minute 15 P M.
 21. I hereby certify that I attended the deceased from March 1 1940
2-16-40, 1940, to March 1 1940
 that I last saw her alive on 2-29-40, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis with cardiac de-
compensation

Due to _____
 Due to _____
 Other conditions (include pregnancy within 3 months of death) _____
 Major findings: _____
 Of operations _____
 Of autopsy None

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 1

23. Signature Dr. De Mone MD (M. D. or other)
 Address Supt. K. C. Gen. Hospital, K. C. Mo. 8-2-40

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

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

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.

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 E. P. Casey

Licensed Embalmer No. 1872

P. O. Address. 3024 Troost

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.