

FILED APR 12 1940

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

9565

Do not use this space.

999

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Raw Primary Registration District No. 1002 Registered No. 999
 (c) City Kansas City (d) Street No. St. Luke's Hospital 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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

10 HOFF, MRS. (Cliffie) May (Mrs. Cliffie May Hoff)
 (a) Residence, No. Stockton, Mo. St. Stockton, 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 F 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 CHESTER W

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 28, 1899

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
40 6 5

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
 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) Cedar Co., Mo.
 (STATE OR COUNTRY)

FATHER 13. NAME H. S. Morris

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

MOTHER 15. MAIDEN NAME Lillie May Clark
 16. BIRTHPLACE (CITY OR TOWN) Cedar Co., Mo.
 (STATE OR COUNTRY)

17. INFORMANT Chester Hoff
 (ADDRESS) Stockton, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Stockton City, Mo. DATE 3-6-40

19. FUNERAL DIRECTOR (NAME) W. B. Davis
 (ADDRESS) Stockton, Mo.

20. FILED 3-4- 19 40 M. M. Brown
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 3, 1940

22. I HEREBY CERTIFY, That I attended deceased from

19 March 3 to March 3, 19 40 Death is said to have occurred on the date stated above, at 12:30 A.M.
 The principal cause of death and related causes of importance were as follows:

SHOCK, SURGICAL, DELAYED.
ACUTE CARDIAC DILATATION
ACUTE HEPATITIS
ACUTE NEPHRITIS (CLOUDY SWELLING)
CHRONIC FIBROID TUBERCULOSIS,
PULMONARY
 Other contributory causes of importance:
CHOLECYSTECTOMY
CHRONIC ADHESIVE PLEURITIS
RIGHT, COMPLETE, PARTIAL LEFT.
 Name of operation CHOLECYSTECTOMY Date of 2-25-40
 What test confirmed diagnosis? Clinical 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? No
 If so, specify _____
 (Signed) E. Lee Miller M. D.
 (Address) Professional Bldg
K.C. Mo.

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 Cecil R. Matthes

• Licensed Embalmer No. 3807

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9565X
Registrar's No. 999-

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No.

Primary Registration District No.

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town R.C.
(c) Name of hospital or institution:
H. Luker
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Cliffie May Hoff

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

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

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

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

17. (a) (burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address May 1948

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

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Mar 3 day 40 year _____ hour _____ minute _____ M.

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

Immediate cause of death Chock - bacterial
Acute Cardiac Disturbance
Acute Hepatitis
Acute nephritis - cloudy swelling
Chr. Fibroid of R. Pulmonary
Due to Chr. adhesive pleuritis
Rt. comp. Lt. pulm.
Other conditions _____ (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: Cholecystectomy 2-29-40
Of operations: for gallstones
Of autopsy _____
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 _____

23. Signature E. Lee Miller (M. D. or other) M.D.

Address 1032 P. of Bldg Date signed 5-13-40

SUPPLEMENTARY

1940
S-9565