

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.

JUN 15 1940
Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 4299

1. PLACE OF DEATH:
(a) County _____
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2223 CHEROKEE ST.
(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 ETHEL HOFSTETTER
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife EMIL HOFSTETTER 6. (c) Age of husband or wife if alive 42 years
7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years abt 48 Months _____ Days _____ If less than one day
hr. _____ min. _____

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

10. Usual occupation HOUSEWIFE

11. Industry or business _____
12. Name UNKNOWN
13. Birthplace GERMANY
(City, town, or county) (State or foreign country)
14. Maiden name UNKNOWN
15. Birthplace GERMANY
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature EMIL HOFSTETTER
(b) Address 2223 CHEROKEE

17. (a) BURIAL (b) Date thereof MAY 15 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation BETHANY CEMETERY

18. (a) Signature of funeral director Thos Rutis
(b) Address 2906 Gravois

19. (a) MAY 14 1940 (b) _____
(Date received local registration) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County _____
(c) City or town ST. LOUIS 24
(If outside city or town limits, write "RURAL")
(d) Street No. 2223 CHEROKEE
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month MAY day 12
year 1940 hour 10 minute 30 P. M.
21. I hereby certify that I attended the deceased from 12-15-39
5-12-40, 1940, to 5-12-40, 1940;
that I last saw her alive on 5-12-40, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death
Carcinoma of Lung
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: no
Of operations _____
Of autopsy no
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 _____
23. Signature J. B. Boudreau (M. D. or other) _____
Address 406 S. Duquesne Date signed 5/13/40

4055 Le Grand

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.....

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

Signed *Leo Budde*.....
Licensed Embalmer No. *3989*
P. O. Address *St. Louis, Mo.*

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.