

No. 2
-11-10-39
-5-17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **25436**

REC AUG 9 1940

Registration District No. **411**

Primary Registration District No. **2002**

Registrar's No. _____

49
7
5

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

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Joplin, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Johns Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 weeks
(Specify whether
In this community 22 days
years, months or days)

3. (a) PRINT FULL NAME Maxim C. Hoffman

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

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Mr. F. Hoffman (deceased) 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb. 3 1917
(Month) (Day) (Year)

8. AGE: Years 62 Months 5 Days 3 If less than one day _____ hr. _____ min.

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

10. Usual occupation H.W.

11. Industry or business _____

MOTHER-FATHER { 12. Name Bigelow Crocker
13. Birthplace Near Chillicothe Mo
(City, town, or county) (State or foreign country)
14. Maiden name Margaret Crocker
15. Birthplace Near Chillicothe Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Henry E. Hoffman
(b) Address Meridian Okla

17. (a) Mt Hope Joplin Mo (b) Date thereof 7-8-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt Hope Joplin Mo

18. (a) Signature of funeral director Cooper Thomas Horn
(b) Address Meridian Okla

19. (a) 7-8-40 (b) Ed E. Jernez
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Oklahoma (b) County Ottawa
(c) City or town Meridian
(If outside city or town limits, write "RURAL")
(d) Street No. 203 C Northwest
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 6
year 1940 hour 3 minute 15 A.M.

21. I hereby certify that I attended the decedent from Jan 1940 to Jul 5 1940
that I last saw her alive on Jul 5 and that death occurred on the date and hour stated above.

Immediate cause of death Ch. Myocarditis
Due to Acute
Due to 47 C

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____

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?
372 While at work? _____ (Specify type of place)
(e) Means of injury 1. W
23. Signature [Signature] (M. D. or other) 1. W
Address Joplin, Mo Date signed 7/11/40

Duration 2 yrs
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

40-8-332

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. **2079**

working under my personal supervision.

Signed _____

V. D. Cooper

Licensed Embalmer No. _____

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.