

FILED OCT 11 1940

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

1. PLACE OF DEATH: Boone
 (a) County Boone
 (b) City or town Columbia
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Boone Co. Hosp
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 10 hours
 In this community Life
 years, months or days (Specify whether)

3. (a) PRINT FULL NAME LINDA GAIL HOFFMAN
 3. (b) If veteran, name war Baby
 3. (c) Social Security No. Baby

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Baby
 6. (b) Name of husband or wife X
 6. (c) Age of husband or wife if alive X years

7. Birth date of deceased July 16th 1940
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
X 2 X hr. min.

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

10. Usual occupation Baby

11. Industry or business Baby

MOTHER FATHER { 12. Name Carson Clyde Hoffman

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

14. Maiden name Millie Alice GATES

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

16. (a) Informant B. E. Hoffman

(b) Address 1818 Wilson Columbia Mo

17. (a) Burial (b) Date thereof Sept 17-1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bonne Femme

18. (a) Signature of funeral director R. O. Willett

(b) Address Columbia Mo

19. (a) 9/20/40 (b) Allie Selby
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Boone
 (c) City or town Columbia
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1818 Wilson Ave Columbia
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 16th
 year 1940 hour 4:45 P.M. minute _____ P. M.

21. I hereby certify that I attended the deceased from 9/12, 1940 to 9/16, 1940
 that I last saw her alive on 9/16, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumonia Duration 2 days
 Due to Quintessence from Congenital Heart Disease Life
 Due to _____

Other conditions (Include pregnancy within 3 months of death) 1570

Major findings: Of operations _____
 Of autopsy no 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?
74 (Specify type of place) (e) Means of injury _____
 While at work? _____
 23. Signature J. H. Madson (M. D. or other) _____
 Address 205 Exchange Bldg Date signed 9/16/40

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.

Empty Only

Signed *[Signature]*
Licensed Embalmer No. *3183*

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.