S. No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34449

NOV 12 1940

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 3965

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3321 Bellefontaine 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits write "RURAL")

0 (d) Street No. 3321 Bellefontaine
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Oretta L. Hoffman

3. (b) If veteran, name war ------ 3. (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 Jacob B. Hoffman 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased August (Month) 10, (Day) 1875 (Year)

8. AGE: Years 65 Months 2 Days 4 If less than one day _____ hr. _____ min.

9. Birthplace Joplin (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation Housewife 4

11. Industry or business 0

FATHER
12. Name Newton Wellman
13. Birthplace _____ (City, town, or county) No record (State or foreign country)

MOTHER
14. Maiden name Suzan Freaner
15. Birthplace _____ (City, town, or county) Ohio (State or foreign country)

16. (a) Informant Jacob B. Hoffman
(b) Address 3321 Bellefontaine

17. (a) burial (Burial, cremation, or removal) (b) Date thereof Oct. 16, '40 (Month) (Day) (Year)
(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director Gates Funeral Home
(b) Address Kansas City, Kansas

19. (a) 10-15-40 (Date received local registrar) (b) M M Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 14
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Jan 31, 1939, to Oct 14, 1940
that I last saw her alive on Oct 12, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho Pneumonia — Duration 5 days

Due to Endocarditis, Chronic

Due to _____ 92 a

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

Major findings:
Of operations ✓
Of autopsy ✓

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? _____ (Specify type of place)
While at work? _____ (e) Means of injury ✓

23. Signature W R F Foster M D (M. D. or other)
Address 1529 Lister Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

Dr. Ferster
1529 Lister

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 D Ross Blanford

Licensed Embalmer No. 4015

P. O. Address 4148 State L

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.