

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

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.

DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 36272

Registration District No. 780

Primary Registration District No. 4466

Registrar's No. 53

1. PLACE OF DEATH:

(a) County Ste. Genevieve
 (b) City or town Ste. Genevieve
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution L
 (Specify whether
 In this community _____
 years, months or days)

3. (a) PRINT FULL NAME ELIZABETH HOFFMAN

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

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed

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

7. Birth date of deceased Oct 31 1858
 (Month) (Day) (Year)

8. AGE: Years 81 Months 11 Days 25
 If less than one day _____ hr. _____ min.

9. Birthplace River and Main Mo
 (City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business _____

MOTHER FATHER
 12. Name Ignatius Roth
 13. Birthplace Germany
 (City, town, or county) (State or foreign country)
 14. Maiden name Magdalena Huser
 15. Birthplace Germany
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Charles J. Hoffman
 (b) Address Ste. Genevieve Mo

17. (a) Burial (b) Date thereof Oct 29 40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ste. Genevieve Mo

18. (a) Signature of funeral director Geo. C. Dooler
 (b) Address Ste. Genevieve Mo

19. (a) Oct 29/40 (b) T.W. Douglas
 (Date received from registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ste. Genevieve
 (c) City or town Ste. Genevieve
 (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 Oct. day 26
 year 1940 hour _____ minute 4:30 P.M.

21. I hereby certify that I attended the deceased from 10-19, 1940, to Oct 26, 1940,
 that I last saw her alive on Oct. 26, 1940,
 and that death occurred on the date and hour stated above.

Immediate cause of death bronchial pneumonia Duration 2 days

Due to Septicemia 6 days

Due to _____

Other conditions arterio-sclerosis, hypertension ?
 (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?

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

23. Signature Robert H. Layman (M. D. or other) _____
 Address Ste. Genevieve, Mo Date signed 10/26/40

PHYSICIAN
 Underline the cause to which death should be charged statistically

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.....

Lea C. Parker....., Registered Apprentice No.....
working under my personal supervision.

Signed Lea C. Parker.....

Licensed Embalmer No. 1985.....

P. O. Address. St. Lawrence.....

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.