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FEB 18 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3834

Registration District No. 677

Primary Registration District No. 4403

Registrar's No. 34

1. PLACE OF DEATH: Phelps
 (a) County Phelps
 (b) City or town Rolla
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
 (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

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Phelps 81
 (c) City or town Rolla 2
 (If outside city or town limits, write "RURAL") 2
 (d) Street No. _____ (If rural, give location) 0
 (e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME John Wilhelm Carl Hoffman
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Feb day 5th
 year 1941 hour 5:30 date 30 PM

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced M
 6. (b) Name of husband or wife Marie Aldag Hoffman 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased April 30, 1858
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1-12-41, 1941 to 2-5, 1941
 that I last saw him alive on 2-5, 1941
 and that death occurred on the date and hour stated above.

8. AGE: Years 82 Months 9 Days 5 If less than one day _____ hr. _____ min.

Immediate cause of death venia
 Duration 2 da
 Due to _____
 Due to _____

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

Other conditions chronic myocarditis
 (Include pregnancy within 3 months of death) Senility

10. Usual occupation _____
 11. Industry or business Retired Farmer
 12. Name Fred Hoffman
 13. Birthplace Germany 4
 (City, town, or county) (State or foreign country)
 14. Maiden name Elizabeth Hale
 15. Birthplace Germany 4
 (City, town, or county) (State or foreign country)

Major findings:
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant Arthur Hoffman
 (b) Address Woodward Iowa
 17. (a) Burial (b) Date thereof Feb 8, 1941
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Dundee Ill
 18. (a) Signature of funeral director Mrs Harry McCaw
 (b) Address Rolla Mo.
 19. (a) Feb 6, 1941 (b) Joe F. Ayers
 (Date received local registrar) (Registrar's signature)

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?
IN
 (Specify type of place) _____ (e) Means of injury _____
 While at work? _____
 23. Signature E. E. Feindel, D.M.D. or other 11
 Address Rolla Mo. Date signed 2-6-41

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

93A

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..... *R. E. McLaw*

Licensed Embalmer No. *3953*

P. O. Address..... *Rolla*

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 38347

Registration District No. 677

Primary Registration District No. 4403

Registrar's No. _____

1. PLACE OF DEATH

(a) County Polk
(b) City or town Rolla
(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 _____
(Specify whether _____)
In this community _____
years, months, or days

3. (a) PRINT FULL NAME John W. Carl Hoffman
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

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

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
82 9 5- _____ hr _____ min

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name (City, town, or county) (State or foreign country)

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

20. DATE OF DEATH Month Feb day 5-
year 1974 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death uremia Duration _____
Cause Inv.

Due to _____

Due to _____

Other conditions chr. mep. Carditis
(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? _____

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

23. Signature E. E. Faid (M. D. or other)

Address Rolla, Mo. Date signed 2-23

SUPPLEMENTARY

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

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3834

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 677

Primary Registration District No. 4403

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Shelby
(b) City or town Rolla
(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 _____ (Specify whether
In this community _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME John Wilhelm Carl Hoffman

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased. (Month) _____ (Day) _____ (Year) _____

8. AGE: Years 82 Months 9 Days 5 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof. (Month) _____ (Day) _____ (Year) _____

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 Feb day 5 year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death uremia
N. M. D.

Due to _____

Due to _____

Other conditions chr. myocarditis
(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? _____

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

23. Signature E. E. [Signature] (M. D. or other) [Signature]

Address Rolla Mo Date signed _____

Duration 3 weeks

PHYSICIAN

Underline the cause to which death should be charged statistically.