

Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **3500 Miami St.**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **18 Years** (Specify whether  
in this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME **Julia Hoffmann**

3. (b) If veteran, name war **---** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow**

6. (b) Name of husband or wife **George** 6. (c) Age of husband or wife if alive **--** years

7. Birth date of deceased **March 14, 1862**  
(Month) (Day) (Year)

8. AGE: Years **79** Months **3** Days **11** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **Unknown / Illinois**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Home**

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name **Valentine Beck**

13. Birthplace **Unknown / Germany**  
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Unknown / Illinois**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Florence Robinson**

(b) Address **3500 Miami St.**

17. (a) **Burial** (b) Date thereof **6/28/41**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Old St. Marcus**

18. (a) Signature of funeral director **Wacker-Welderle**

(b) Address **3634 Gravois Ave**

19. (a) **JUN 27 1941** (b) **J. F. Brudek**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County \_\_\_\_\_  
(c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **3500 Miami St.**  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country **U**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **25**  
year **1941** hour **7** minute **45a.** M.

21. I hereby certify that I attended the deceased from **June 16th, 1941 to June 25th, 1941**  
that I last saw her alive on **June 24th, 1941**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage (Apoplexy)**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions **Arteriosclerosis**  
(Include pregnancy within 3 months of death)

Major findings: Of operations **XXX**  
Of autopsy **XXX**

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence **XX**  
(c) Where did injury occur? **XX**  
(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) \_\_\_\_\_  
1c. Means of injury \_\_\_\_\_  
23. Signature **Dr. W. H. Melton** (M. D. or other M. D.)  
Address **3608 So. Grand Blvd.** Date signed **6/25/41**

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

50  
77  
9

900  
2617  
9

83  
A  
A

Duration  
1 wk  
1 yr.  
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.....

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed..... *Frank J. Noland*  
Licensed Embalmer No. *2945*  
P. O. Address..... *Grand Ave*

**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.**