

AUG 28 1941

Registration District No. 791

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Ms Baptist Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days
In this community 13 years, months or days (specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Louis
(c) City or town Normandy
(If outside city or town limits, write "RURAL")
(d) Street No. 5371 Gladstone
(If rural, give location)
(e) Citizen of foreign country? No
If yes, name country _____

3. (a) PRINT FULL NAME Stan William Hofmann

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

4. Sex male 5. Color or race White 6. (a) Single/widowed, married, divorced Infant

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

7. Birth date of deceased July 1941
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 3 If less than one day _____ min.

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

10. Usual occupation Child

11. Industry or business _____

12. Name Stan Raymond Hofmann

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

14. Maiden name Elaine Anderson

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

16. (a) Informant James J. Ferguson

(b) Address 1300 E. 1st

17. (a) _____ (b) Date thereof 7-28-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Louis

18. (a) Signature of funeral director W. Richter

(b) Address 2500 Ruyter

19. (a) JUL 29 1941 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 9
year 1941 hour 8 minute 15 P.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 _____

Prematurity
Cause undetermined

Due to _____

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy no

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 [Signature] (M. D. or other) 3

Address [Signature] Date signed 7/9/41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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.....

Licensed Embalmer No.....

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 23813
Registrar's No. 6155

Registration District No. 791

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
no Baptist Hosp
(If not in hospital or institution, write street number of location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME Don W. Hoffmann

3. (b) If veteran, name war..... (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 Months Days If less than one day..... 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.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 9-16-41 (b) J.F. Bredbeck
(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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Year 1941 Hour..... Minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....
that I or saw him alive on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Duration

Due to.....

Due to.....

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?..... (Specify type of place) (c) Means of injury.....

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

Address..... Date signed.....

SUPPLEMENTARY

