

No. 2
-1-4-41
5-17-39
I X28

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27040**
Registrar's No. **6832**

Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH: **1941**
(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:
Deaconess Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **8 days**
(Specify whether
in this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **St. Louis**
(c) City or town **Lemay**
(If outside city or town limits, write "RURAL"
(d) Street No. **129 W. Velma av.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Magdaline Hoffmann**
(b) If veteran, name war **None**
(c) Social Security No. **None**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **August** day **21**
year **1941** hour **7** minute **30 a.** M.

4. Sex **Female** / 5. Color or race **White**
6. (a) Single, widowed, married, divorced **widowed**
6. (b) Name of husband or wife **Jacob Hoffmann**
6. (c) Age of husband or wife if alive **1858** years

21. I hereby certify that I attended the deceased from **Aug 13-41**
to **Aug 20** 19**41**
that I last saw **her** alive on **Aug 20** 19**41**
and that death occurred on the date and hour stated above.

7. Birth date of deceased **December 26 1858**
(Month) (Day) (Year)
8. AGE: Years **82** Months **7** Days **25** If less than one day
hr. min.

Immediate cause of death **Cerebral Thrombosis**
arteriosclerosis
Due to.....
Duration **2 days**

9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)
At Home

Other conditions **83**
(Include pregnancy within 3 months of death)
Major findings:
Of operations.....
Of autopsy **eyes - as above**

10. Usual occupation.....
11. Industry or business.....
12. Name **Unknown**
13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

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) or Means of injury.....

16. (a) Informant **Rosa W. Marcus**
(b) Address **405 Hoffmeister ave.**
17. (a) **Burial** (b) Date thereof **Aug. 25-41**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **New St. Johns Cemetery**
18. (a) Signature of funeral director **C. Hoffmeister**
(b) Address **7814 S. Broadway**
19. (a) **AUG 22 1941** (b) **J. P. Budeck**
(Date received local registrar) (Registrar's Signature)

23. Signature **E. J. Scholer** (M.D.)
Address **94 S. Mo Blvd** Date signed **8/22/41**

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

30
17
9

OCT 24 1941

2-4 pm

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 *Linus C. Hoffmeister*

Licensed Embalmer No. *3871*

P. O. Address *7814 S. Broad*

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.