

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
512 East 57th Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 months
(Specify whether years, months or days) both

3. (a) PRINT FULL NAME Anna Catherine Hoffmaster

3. (b) If veteran, name war no 3. (c) Social Security No. none

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

6. (b) Name of husband or wife John Wheeler Hoffmaster 6. (c) Age of husband or wife if alive 8 years

7. Birth date of deceased April 1859
(Month) (Day) (Year)

8. AGE: Years 83 Months 0 Days 27 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER { 12. Name Jacob Benrath
13. Birthplace Holland
(City, town or county) (State or foreign country)
14. Maiden name Catherine Bayer
15. Birthplace Germany
(City, town or county) (State or foreign country)

16. (a) Informant Daughter Gertrude Hoffmaster

(b) Address 1512 E 57th

17. (a) Removal (b) Date thereof 5-7-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sedalia, Mo

18. (a) Signature of funeral director Mrs. P. D. Forster

(b) Address M. M. Crow

19. (a) May 5, 1942 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 512 E 57th
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 5th
year 1942 hour No minute 15 P.

21. I hereby certify that I attended the deceased from Jan 13 1942 to May 5 1942
that I last saw her alive on May 5 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 4 mos.

Due to Arterio-sclerosis

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)
(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 Robert Jansen (M. D. or other) M.D.
Address 2220 E 31st St. Date signed 5-5-42

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

AUG 26 1942

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

Signed C. H. White

Licensed Embalmer No. 2570

P. O. Address Kansas City, Mo

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.