

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.....

FILED FEB 25 1943
818

1003

Registrar's No. 1430

Registration District No.....

Primary Registration District No.....

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:
Jewish Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
(Specify whether

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..... **4173 Lafayette**
(If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME..... **Minnie Hofflin**
 3. (b) If veteran, name war.....
 3. (c) Social Security No.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **12**
 year **1943** hour **12** minute **20 P. M.**
 21. I hereby certify that I attended the deceased from **Dec. 12**
 19 **42** to **Feb. 12**, 19 **43**
 that I last saw her alive on **Feb. 12**, 19 **43**
 and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife..... **Walter L. Hofflin**
 6. (c) Age of husband or wife if alive **76** years
 7. Birth date of deceased **May 3** **1867**
(Month) (Day) (Year)

Immediate cause of death.....
Coronary disease
 Duration **2 mo**

8. AGE: Years Months Days If less than one day
75 **9** **9** hr. min.

Due to.....
 Due to.....

9. Birthplace..... **Madison Wisconsin**
(City, town, or county) (State or foreign country)
 10. Usual occupation..... **at home**

Other conditions.....
(Include pregnancy within 3 months of death)
Hypertensive arterio-sclerotic vascular disease
 Duration **2 yrs**

11. Industry or business.....
 12. Name..... **unknown**
 13. Birthplace..... **Austria**
(City, town, or county) (State or foreign country)
 14. Maiden name..... **unknown**
 15. Birthplace..... **Austria**
(City, town, or county) (State or foreign country)

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

16. (a) Informant..... **Meyer K. Weal**
 (b) Address..... **815 S. Bemiston**
 17. (a) **Burial** (b) Date thereof **2-14-1943**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation..... **Mt. Olive Cemetery**
 18. (a) Signature of funeral director.....
 (b) Address..... **5216 Delmar Blvd.**
 19. (a) **FEB 13 1943** (b) **J. F. Bruce**
(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?
 While at work?.....
(Specify type of place) (e) Means of injury
 23. Signature..... **Peter J. Pholske** (M. D. or other)
 Address..... **462 N. FAYLOR AVE.** Date signed **2/13/43**

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

MOTHER FATHER

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 Chris W. Cooper
Licensed Embalmer No. 3830
P.O. Address 5216 Delmar

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.