

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

LED MAY 27 1943 318
Registration District No.

Primary Registration District No. 1000 Registrar's No. 4467

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:
Route to City Hospital H-132
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community..... years, months or days)

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. 4437 GANNETT
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME WALTER HOFER

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. MARRIED
6. (b) Name of husband or wife. ALICE HOFER 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased. NOV 1 1897
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
45 6 11 hr. min.

9. Birthplace. NEW YORK
(City, town, or county) (State or foreign country)

10. Usual occupation. SHOE WORKER

11. Industry or business. INTERNATIONAL SHOE CO.

MOTHER FATHER { 12. Name. FRED HOFER
13. Birthplace. SWITZERLAND
(City, town, or county) (State or foreign country)
14. Maiden name. BERTHA SCHULTZ
15. Birthplace. GERMANY
(City, town, or county) (State or foreign country)

16. (a) Informant. Mrs Alice Hofer
(b) Address. 4437 Gannett
17. (a) BURIAL (b) Date thereof. MAY 15 43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation. CALVARY CEM.

18. (a) Signature of funeral director. E. J. Schur
(b) Address. 3125 Lafayette Ave.

19. (a) MAY 1943 (b) J. J. Bredsch
(Date received local registrar's certificate) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 12
year 1943 hour 8 minute 45 A.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. Coronary Occlusion
Arteriosclerosis
Due to.....
Due to.....
Other conditions. g.i.
(include pregnancy within 3 months of death)

Duration

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) (a) Means of injury.....
23. Signature. Alfred Perry (M. D. or other) 3
Address. Naupaug Conn Date signed. 5/13/43

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

JUN 29 1940

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.....

Joe B. Vollmer

Licensed Embalmer No. *4014*

P. O. Address *3125 Lafayette 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.