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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26745**

FILED SEP 3 1943 818

Registration District No. _____

Primary Registration District No. **1003**

Registrar's No. **7718**

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

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:
1415 E. Prairie Ave.
(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. **1415 E. Prairie**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Joseph H. Hoffmeyer**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **None**

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Widowed**

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

7. Birth date of deceased **October 21 1874**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
68 10 6 hr. min.

9. Birthplace **Germany 4**
(City, town, or county) (State or foreign country)

10. Usual occupation **Carpenter**

11. Industry or business _____
12. Name **Anton Hoffmeyer**

13. Birthplace **Germany 4**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Germany 4**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Frances Pfeiffer**

(b) Address **4829 Calvin Ave.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **8-31-43**
(Month) (Day) (Year)

(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **Stroot-Carroll**

(b) Address **4600 Natural Bridge Ave.**

19. (a) **AUG 28 1943** (Date received local registrar) **J. J. Brueck** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **27**, year **1943** hour **10** minute **25 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 Arterio Sclerosis**

Due to **9 H**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy _____

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) (c) Means of injury **3**
23. Signature **Alfred J. Perry** (M. D. or other) _____
Address _____ Date signed **8/28/43**

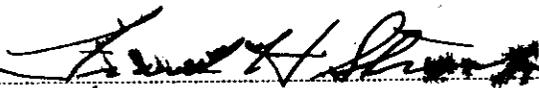
Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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. 2265

P. O. Address 4600 Mt Bridge

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.