

7. S. No. 2
FORM-5-42
Rev. 5-17-39
I X32873

34509

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED NOV 25 1943

Registration District No. 82

Primary Registration District No. 3017

Registrar's No. 135

1. PLACE OF DEATH:

(a) County Cooper

(b) City or town Boonville, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Josephs Hospital
(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 Mo. (b) County Lewis 45

(c) City or town Boonville 3
(If outside city or town limits, write "RURAL") 0

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME TRANCE HOFFMAN.

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 19
year 1943 hour 10 minute 15 P.M.

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct 19 - 1943
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct 19 1943 to Oct 19 1943
that I last saw him alive on Oct 19 1943
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>0</u>	<u>0</u>	<u>8</u> hr. _____ min.

Immediate cause of death: Congenital absence of brain tissue.

Due to Congenital malformation of head + skull.

Due to _____

9. Birthplace Cooper Co. Boonville, Mo.
(City, town, or county) (State or foreign county)

Other conditions (Include pregnancy within 3 months of death) 157 AM

10. Usual occupation _____

11. Industry or business _____

Major findings: Of operations _____

Of autopsy grossly deformed head & practically no brain tissue.

MOTHER FATHER

12. Name Arthur B Hoffman

13. Birthplace Mokane Mo
(City, town, or county) (State or foreign country)

14. Maiden name Leola May Berry

15. Birthplace Mokane Mo
(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? _____

16. (a) Informant Arthur B Hoffman

(b) Address Franklin Mo

23. Signature Geo. W. Blankenship 9/18/0
Address Boonville Mo. Date signed _____

17. (a) Interment (b) Date thereof 10/20/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Charles Choppe

18. (a) Signature of funeral director E. S. Weir

(b) Address New Franklin Mo.

19. (a) Oct-20-43 (b) Dr. Chas. Sweep
(Date received local registrar) (Registrar's signature)

1048

(Licensed Embalmer's Statement on Reverse Side)

10-22-43

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

27
1
2

RECEIVED
City of New York
11-3-43

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 R. L. Pace

Licensed Embalmer No. 3515

P. O. Address New Franklin

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.