

No. 2  
1-2-43  
5-17-39  
K35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3647c

State File No. \_\_\_\_\_

FILED NOV 18 1943 18

Registrar's No. **9691**

Registration District No. \_\_\_\_\_

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town St. Louis, Missouri  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
4432 Washington Blvd.  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
 In this community \_\_\_\_\_ (Specify whether  
 years, months or days)

3. (a) PRINT FULL NAME Lila Belle Hoffman

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

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

6. (b) Name of husband or wife Oscar Hoffman 6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased December 31 1875  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
67 10 2 \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Greenville Illinois  
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business At Home

12. Name Henry E. Reed

13. Birthplace Auburn Ohio  
 (City, town, or county) (State or foreign country)

14. Maiden name Kate Kehoe

15. Birthplace Unknown Unknown  
 (City, town, or county) (State or foreign country)

16. (a) Informant Floy McKittrick

(b) Address 4432 Washington Blvd.

17. (a) Removal (b) Date thereof 11/4/43  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Festus, Missouri.

18. (a) Signature of funeral director Albert H. Hoppe, I

(b) Address 4700 Washington Blvd.

19. (a) NOV 4 1943 (b) J. F. Bredick  
 (Date received local registrar) (Registrar's signature)

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. 4432 Washington Blvd.  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 3  
 year 1943 hour 7 minute 50 A. M.

21. I hereby certify that I attended the deceased from March 10 1943 to Nov 7 1943  
 that I last saw her alive on Nov 6 1943  
 and that death occurred on the date and hour stated above.

Immediate cause of death Ar. Myocardial Failure Duration 1 day  
 Due to Hemiplegia, Lt. from stroke Duration 9 mos

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 R. Nakada (M. D. or other) \_\_\_\_\_  
 Address Humboldt Bldg. Date signed 11/14/43

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 *Albert H. Happe*

Licensed Embalmer No. *1861*

P. O. Address.....

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 9691

1. PLACE OF DEATH

(a) County St. Louis

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

(c) Name of hospital or institution:  
\_\_\_\_\_  
(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. 4432 Washington  
(If rural, give location)

(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Lela Belle Hoffman

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month 11 day 3  
year 1945 hour 7:50 minute 2 P.M.

4. Sex \_\_\_\_\_

5. Color or race \_\_\_\_\_

6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ year

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 3-11-45 to 11-3-45, 1945 that I last saw him alive on 11-2, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

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

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER {

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 12-4-45 (b) J. F. Dredach  
(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)

Means of injury \_\_\_\_\_

23. Signature J. P. Nakada (M. D. or other)

Address Thurston Bldg. Date signed 11-4-45

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

SUPPLEMENTARY

36476