

FILED NOV 24 1943

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

Primary Registration District No. 2.000

1. PLACE OF DEATH:

(a) County GREENE  
(b) City or town SPRINGFIELD MO.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
2050 W. HIGH 1 ST.  
(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 GREENE  
(c) City or town SPRINGFIELD  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2050 W. High St  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 3rd  
year 1943 hour 7:00 minute \_\_\_\_\_ P.M.  
21. I hereby certify that I attended the deceased from 8/31 1943 to 11-2 1943  
that I last saw h alive on 11-2 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Myelogenous Leukemia Duration 1 year

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

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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 C. E. Feller (M. D. or other)  
Address Springfield Mo. Date signed 11-4-43

3. (a) PRINT FULL NAME CLARA 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 ALBERT R. HOFFMAN 6. (c) Age of husband or wife if alive 69 years  
7. Birth date of deceased June 20 1874  
(Month) (Day) (Year)

8. AGE: Years 69 Months 4 Days 13 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Manistee Mich.  
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business In home

MOTHER FATHER { 12. Name Wm Krueger  
13. Birthplace Uak Germany  
(City, town, or county) (State or foreign country)  
14. Maiden name Theresa Achteberg  
15. Birthplace Uak Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant Albert R. Hoffman  
(b) Address SPRINGFIELD MO.

17. (a) Burial (b) Date thereof Nov 7-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Green Lawn Cem

18. (a) Signature of funeral director J. W. Klingner  
(b) Address SPRINGFIELD MO.

19. (a) 11-4-43 (b) W. Handley  
(Date received local registrar) (Registrar's signature)

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

MAY 19 1953

**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.....

.....  
working under my personal supervision.

Registered Apprentice No. ....

Signed.....

Licensed Embalmer No. ....

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.**

*Max Rhodes*  
4071  
Springfield  
X