

FILED DEC 8 1943

Registration District No. **179**

Primary Registration District No. **5667**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **LINCOLN**
(b) City or town **TROY RFD.**
(c) Name of hospital or institution: **1221 1/2 1st St Troy**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **2 years** years, months or days

3. (a) PRINT FULL NAME **FRANK M. Hoffelder**

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 **divorced**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive **7 years** years

7. Birth date of deceased **August 17 - 1867**
(Month) (Day) (Year)

8. AGE: Years **76 yrs** Months **2** Days **10** If less than one day hr. _____ min. _____

9. Birthplace **St Louis MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business **None**

MOTHER { 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)

16. (a) Informant _____

(b) Address **TROY, MO.**

17. (a) **BURIAL** (Burial, cremation, or removal) (b) Date thereof **10/30/43**
(Month) (Day) (Year)

(c) Place: burial or cremation **Mount Hope Cemetery**

18. (a) Signature of funeral director **Walker - King Mortuary**

(b) Address **784 YMERAMES ST**

19. (a) **Nov 12/43** (Date received local registrar) (b) **Mrs Fay Jackson** (Registrar's signature)

20. DATE OF DEATH: Month **Oct.** day **27** year **1943** hour **4:20** minute **AM**

21. I hereby certify that I attended the deceased from **Jan - 10, 1943** to **Oct 27, 1943** that I last saw him alive on **Oct 27, 1943** and that death occurred on the date and hour stated above.

Immediate cause of death **Central Apoplexy**

Due to **Arterio-sclerosis**

Due to **101 mg per cent sodium - 5 yrs**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **LINCOLN**
(c) City or town **TROY RFD. MO**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **27** year **1943** hour **4:20** minute **AM**

21. I hereby certify that I attended the deceased from **Jan - 10, 1943** to **Oct 27, 1943** that I last saw him alive on **Oct 27, 1943** and that death occurred on the date and hour stated above.

Immediate cause of death **Central Apoplexy**

Due to **Arterio-sclerosis**

Due to **101 mg per cent sodium - 5 yrs**

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 work)
(e) Means of injury _____

23. Signature **Geo. E. B. ...**

Address **Troy, Mo.** Date signed **Nov 12/43**

Duration

10 hours

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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 S Benz

Licensed Embalmer No.

4749

P. O. Address

7847 Mariamee

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. 179 Primary Registration District No. 5667 Registrar's No. _____

1. PLACE OF DEATH:

(a) County Linn

(b) City or town Bedford Imp.
(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 _____ (b) County _____

(c) City or town _____ (If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Frank M. Hoffelder

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct Day 7 Year 1943 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

4. Sex M 5. Color or race W

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

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

7. Birth date of deceased Aug 17 1866
(Month) (Day) (Year)

Duration _____

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

8. AGE: Years 76 Months 2 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings:
Of operations _____

Of autopsy _____

MOTHER FATHER

11. Industry or business _____

12. Name W. Wolfgent

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

14. Maiden name Annie Kosta

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

16. (a) Informant Mr. James Creech

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Mrs. Fay Jackson
(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) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

38620