

FILED FEB 3 1944
Registration District No. _____

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Jackson City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Vanguard Park Hosp.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 weeks** (Specify whether
In this community **50 yrs** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) **PR** FULL NAME **Herschel Hoffman**

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

4. Sex **male** 5. Color or **white** 6. (a) Single, widowed, married, divorced **divorced**
6. (b) Name of husband or wife **wife** 6. (c) Age of husband or wife if alive **years**
7. Birth date of deceased **May 27 - 1866**
(Month) (Day) (Year)

8. AGE: Years **77** Months **7** Days **14** If less than one day
hr. min.

9. Birthplace **Duck Town Tenn**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Salesman**

11. Industry or business _____

12. Name **Allophus Hoffman**

13. Birthplace **North Carolina**
(City, town, or county) (State or foreign country)

14. Maiden name **Rebecca Sides**

15. Birthplace **North Carolina**
(City, town, or county) (State or foreign country)

16. (a) In **Miss. Raymond Schmidt**

(b) Address **119 E - 51st Terrace**

17. (a) **Burial** (b) Date thereof **Jan 10 - 44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Forest Hill Cem**

18. (a) Signature of funeral director **Wm. C. R. Foster**

(b) Address **918 Broadway St. C. Mo.**

19. (a) **Jan 19, 1944** (b) **S. B. Brown**
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **7**
year **1944** hour **5:30** minute **PM**

21. I hereby certify that I attended the deceased from **Dec 24 - 43**
to **Jan 7 - 44**
that I last saw him alive on **Jan 7 - 44**
and that death occurred on the date and hour stated above. **1944**

Immediate cause of death _____ Duration _____

Due to **Influenza abdominal**
Due to _____

Other conditions **Severe**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy **3300**

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. H. ...** (M. D. or other) _____
Address **1927, Main** Date signed **Jan 8**

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.....

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.