

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

FILED APR 13 1944

12266

Do not use this space.

1. PLACE OF DEATH *Bellevue*
 (a) County *Marshall* Registration District No. *324*
 (b) Township *Marshall* Primary Registration District No. *6093*
 (c) City *Marshall* (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *Carl P. Hoff Jr.*
 (a) Residence, No. _____ St. (If nonresident, give city or town and State) _____
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* **4. COLOR OR RACE** *OW* **5. SINGLE, MARRIED, WIDOWED, OR DIVORCED** *(write the word)* *O*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Sept. 13 - 1915*

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<i>28</i>	<i>5</i>	<i>20</i>		

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ **11. Total time (years) spent in this occupation** _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*

13. NAME *Carl P. Hoff*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Calix Ohio*

15. MAIDEN NAME *Annie Marsh*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Boone Co. Mo.*

17. INFORMANT (ADDRESS) *No State School Record Marshall, Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Springfield* DATE *3-5-44*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Campbell-Lewis Marshall Mo*

20. FILED *Mar. 4, 1944 Mrs. T. O. Westcott*
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *3-3-44* 19*44*

22. I HEREBY CERTIFY, That I attended deceased from *3-1*, 19*44*, to *3-3-44*, 19*44*.
 I last saw him alive on *3-2-44*, 19*44*. Death is said to have occurred on the date stated above, at *9:30 P. M.*
 The principal cause of death and related causes of importance were as follows:
Myocarditis
 Date of onset *3-1-44*

Other contributory causes of importance:
Fragile minded

Name of operation _____ Date of _____
 What test confirmed diagnosis? *Clinical* Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19*44*.
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? *no*
 If so, specify _____
 (Signed) *L. S. James*, M. D.
 (Address) *Marshall, Mo*

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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RECEIVED

File Number _____ Officer No. 8

Date Filed 4-2-44

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 Jan. H. Lewis

Licensed Embalmer No. 1121

P. O. Address Marshall M

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, above space should be left blank.