

No. 2
4-2-43
5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12914
State File No. 4113
Registrar's No.

FILED MAY 13 1944

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County
(b) City or town **St. Louis Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Jewish Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **7 days**
In this community **Life**
(Specify whether 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. **3712 Grandel Sq.**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **ROSE MARKS HOFFMANN**
(b) If veteran, name war (c) Social Security No. **none**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **April** day **30th** year **1944** hour **9:30** minute **P.** M.

4. Sex **female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **wid.**
6. (b) Name of husband or wife **Dr Phillip Hoffmann** 6. (c) Age of husband or wife if alive **19** years
7. Birth date of deceased **October 19, 1870**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 19... to 19... that I last saw him alive on 19... and that death occurred on the date and hour stated above.

8. AGE: Years **73** Months **6** Days **11** If less than one day hr. min.
9. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)

Immediate cause of death **Subdural and Subarachnoid Hemorrhage of the Brain; Aplasia of Bone Marrow; Carcinoma of Brain; when Due to she fell out of bed around 4:00 P.M. April 29, 1944, while being hospitalized at the Jewish Hospital.**

10. Usual occupation
11. Industry or business **At home**
12. Name **Unknown**
13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

WHETHER THE RESULT OF NATURAL CAUSES OR ACCIDENTAL COULD NOT BE DETERMINED
Other conditions (Include pregnancy within 3 months of death)

16. (a) Informant **Lenny E. Oppenheimer**
(b) Address **6165 Waterman Ave**
17. (a) **Cremation** (b) Date thereof **May 4, 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Valhalla Crematory**

Major findings: Of operations
Of autopsy
PHYSICIAN
Underline the cause to which death should be charged statistically.

18. (a) Signature of funeral director **W. J. ...**
(b) Address **4356 Lindell Blvd**
19. (a) **MAY 3 1944** (b) **J. F. ...**
(Date received local registration) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **000**
(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 **W. J. ...** (M. D. or other) **3**
Address **...** Date signed **5/3/44**

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

MAY 24 1960

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.....

John Agonoshi

Licensed Embalmer No. *338*.....

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.