

STANDARD CERTIFICATE OF DEATH

State File No.

FILED AUG 8 1944

Registration District No.

L1003

Registrar's No.

6705

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: BARNES HOSPITAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 56 days  
(Specify whether  
In this community  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Indiana (b) County Clay  
(c) City or town Brazil  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1021 W. National  
(If rural, give location) N.R.  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country 2

3. (a) PRINT FULL NAME CARL ELBERT HOFFMAN

(b) If veteran, name war None (c) Social Security No. unknown

4. Sex Male Color or race White (a) Single, widowed, married, divorced Married

(b) Name of husband or wife Ruby Hoffman (c) Age of husband or wife if alive 29 years

7. Birth date of deceased September 13 1910  
(Month) (Day) (Year)

8. AGE: Years 33 Months 10 Days 15 If less than one day  
hr. min.

9. Birthplace Terra Haute Indiana  
(City, town, or county) (State or foreign country)

10. Usual occupation School Teacher

11. Industry or business

12. Name Clifford Hoffman

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

14. Maiden name Garcia Tibbetts

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

16. (a) Informant Ruby Hoffman

(b) Address Brazil Indiana

17. (a) Removal (b) Date thereof 7-28-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Terre Haute Ind.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave

19. (a) JUL 31 1944 (b) J. F. Bredak  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 28  
year 1944 hour 2:00 minute P.M.

21. I hereby certify that I attended the deceased from June 2  
1944 to July 28 1944  
that I last saw him alive on July 28 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Aremia Duration 5 mo  
Due to Hypertensive cardio vascular disease 5 yrs

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

Major findings:  
Of operations  
Of autopsy confirms above  
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) (Specify type of injury)  
23. Signature Salus Anthony (M. D. or other)  
Address BARNES HOSPITAL Date signed 7-28-44

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

83144

5049

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**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 Ogonoski  
Licensed Embalmer No. 3398  
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.**