

FILED AUG 2 1944

State File No. 2959

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 4 days
(Specify whether
 In this community 52 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
 (c) City or town Kansas City 3
(If outside city or town limits, write "RURAL") 8
 (d) Street No. 1310 Admiral Blvd.
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country 0

3. (a) PRINT FULL NAME Charles F. Hoffman

(b) If veteran, name war No 3. (c) Social Security No. 494-16-3095

4. Sex Male 0 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced 3
 6. (b) Name of husband or wife Goldie Hoffman 6. (c) Age of husband or wife if alive 49 years
 7. Birth date of deceased 3 20 1892
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
52 3 25 hr. min.

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

10. Usual occupation Watchman

11. Industry or business _____

MOTHER FATHER { 12. Name Kirk Hoffman
 13. Birthplace Penn. 1
(City, town, or county) (State or foreign country)
 14. Maiden name Bridget Durkin
 15. Birthplace Kansas 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Earl J. Hoffman
 (b) Address Manhattan Kansas
 17. (a) Burial (b) Date thereof 7-18-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah
 18. (a) Signature of funeral director Mrs. C. L. Forster
 (b) Address Kansas City, Mo.

19. (a) 7-17-44 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15
 year 1944 hour 10 minute 50 P.M.

21. I hereby certify that I attended the deceased from July 11, 1944 to July 15, 1944
 that I last saw him alive on July 15, 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Uremia Malnutrition dehydration
 Due to Extra-Renal uremia
 Due to due to dehydration
 Other conditions due to Acute Alcoholism
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings:
 Of operations _____
 Of autopsy None 790

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)
 (c) Means of injury _____
 23. Signature A. E. Upsher (M. D. or other) MD
 Address Med. Dir. Gen'l Hosp. Date signed 7-19-44

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 *Theron A. Redman*

Licensed Embalmer No. *2737*

P. O. Address: *FLMA*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2959

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Gen. Hosp. #1
(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)

3. (a) PRINT FULL NAME Charles B. Hoffman

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

4. Sex..... 5. Color or race..... 6. (a) Single, widowed, married, divorced.....

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

7. Birth date of deceased..... (Month) (Day) (Year)

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

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

10. Usual occupation.....

11. Industry or business.....

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.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 7-17-44 (b) P. E. Brown (Date received local registrar) (Registrar's signature)

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) If foreign born, how long in U. S. A.?..... years.

20. DATE OF DEATH: July 15 1944
year..... hour..... minute..... M.

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.

Immediate cause of death.....
Due to urgenia
malnutrition
dehydration
Due to extra renal uremia
due to dehydration
Other conditions (include pregnancy within 3 months of death)
due to
Major findings:
Of operations..... acute alcoholism
Of autopsy.....

Duration

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?
..... (Specify type of place)
While at work?..... (c) Means of injury.....
23. Signature A. E. Upsher (M. D. or other).....
Address..... Date signed.....

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

SUPPLEMENTAL

23742