V. S. No. 2
100M—2-43
Rev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 29 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

33201
State File No.

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4128

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town N. C. Mo. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: North East Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Thrs. 25 Min (Specify whether
In this community Thrs. 25 Min years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County JACKSON
(c) City or town KANSAS CITY 47 (If outside city or town limits, write "RURAL")
(d) Street No. 5503 ST. JOHN 38 (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Infant - Hoffman
3. (b) If veteran, name war No.
3. (c) Social Security No. No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased OCT (Month) 16 (Day) 1944 (Year)
8. AGE: Years | Months | Days | If less than one day 7 hr. 25 min.
9. Birthplace Kansas City Mo. (City, town, or county) (State or foreign country)
10. Usual occupation None
11. Industry or business
FATHER
12. Name GEORGE E HOFFMAN
13. Birthplace CHEROKEE (City, town, or county) KANSAS (State or foreign country)
MOTHER
14. Maiden name BETTY LEE
15. Birthplace PITTSBURG (City, town, or county) KANSAS (State or foreign country)
16. (a) Informant MRS. BETTY HOFFMAN
(b) Address 5503 St. John
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/20/44 (Month) (Day) (Year)
(c) Place: burial or cremation Pitts. Burg. Kansas
18. (a) Signature of funeral director Mrs. C. L. Foster
(b) Address 918-920 Brooklyn
19. (a) 10-17-44 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT day 16 year 1944 hour 11:15 minute P M.
21. I hereby certify that I attended the deceased from Oct 16, 1944, to Oct 16, 1944 that I last saw her alive on Oct 16, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death PREMARITY	
Due to	
Due to 159	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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? (e) Means of injury
23. Signature Kenneth L. Mylar (M. D. or other) DO
Address 620 Bennington Date signed 10-16-44

(Licensed Embalmer's Statement on Reverse Side)

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.

Not Embalmed

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.