V. S. No. 2
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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 9 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15206

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4511

20
17
9

1. PLACE OF DEATH:
(a) County —
(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, 6
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 25 days (Specify whether
In this community 70 Years In St Louis years, months or days)

2. USUAL RESIDENCE OF DECEASED: 000
(a) State Missouri (b) County 13 6 16
(c) City or town St Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2915 S Compton Ave.
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME JACOB HOFFMANN
3. (b) If veteran, name war
3. (c) Social Security No. 493-01-8182

4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Katherine Hoffman
6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased March 16 (Month) 1872 (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
73	2	4	hr. min.

9. Birthplace Germany (City, town, or county) U (State or foreign country)
10. Usual occupation Sheet Metal Worker
11. Industry or business

FATHER
12. Name Jacob Hoffman
13. Birthplace Germany (City, town, or county) U (State or foreign country)

MOTHER
14. Maiden name Margaret Becker
15. Birthplace Germany (City, town, or county) U (State or foreign country)

16. (a) Informant Katherine Hoffman
(b) Address 2915 S Compton Ave.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 23/45 (Month) (Day) (Year)
(c) Place: burial or cremation New St Marcus
18. (a) Signature of funeral director Throckitts & Son
(b) Address 2906 Gravois ave.
19. (a) MAY 22 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 20 year 1945 hour 11 minute 45 A. M.
21. I hereby certify that I attended the deceased from Apr. 25, 1945 to May 20, 1945 that I last saw him alive on May 20, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Heart failure	yrs
Due to Arterio sclerotic heart disease	8 yrs
Due to Strain of exploratory thoracotomy	
Other conditions (Include pregnancy within 3 months of death) Ca of esophagus	2-3 yrs

Major findings:
Of operations Ca of esophagus
Of autopsy as 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) (e) Means of injury

23. Signature F R Bradley (M. D. or other)
Address Barnes Hospital Date signed 5/21/45

(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.

Signed David Van Fossan.

Licensed Embalmer No. 4242

P. O. Address 2906 Gravier

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.