No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 18838

FILED JUN 19 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4967

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:
Park Lane Hospital
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Chalres

(c) City or town Wentzville
(If outside city or town limits, write "RURAL")

(d) Street No. NR
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Elizabeth Hoff

3. (b) If veteran, name war Nil

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Frank Hoff

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased March (Month) 6 (Day) 1890 (Year)

8. AGE: Years 55 Months 2 Days ~~5~~ If less than one day hr. min.

9. Birthplace O'Fallon (City, town, or county) Missouri (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name John Dove
13. Birthplace Unknown (City, town, or county) Germany (State or foreign country)

MOTHER
14. Maiden name Bernadine Buckoltz
15. Birthplace Unknown (City, town, or county) Germany (State or foreign country)

16. (a) Informant Mrs. Josephine Douglas
(b) Address St. Charles, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-4-45 (Month) (Day) (Year)
(c) Place: burial or cremation St. Paul, Missouri

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) JUN 4 1945 (Date received local registrar) (b) J. F. Biedeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 1
year 1945 hour 7:45 minute A. M.

21. I hereby certify that I attended the deceased from May Second, 1945 to June 1st, 1945
that I last saw her alive on June first, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Embolus — Duration Instant

Due to Thrombo phlebitis — 10 days

Due to Followed appendectomy Supra Vag hysterectomy Hemorrhoids for fibrous uterus C appendicitis appendicitis — Don't Know

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations Fibrous uterus C appendicitis Hemorrhoids

Of autopsy None made

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 John D Hayward (M. D. or other)

Address Metropolitan Bldg Date signed 6/1-/45

(Licensed Embalmer's Statement on Reverse Side)

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.....

Registration District No..... Primary Registration District No..... Registrar's No.....

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:
(If in a hospital or other institution, write street number or location)

(d) Length of stay: In hospital or institution.....
(Years, months, or days)
In this community.....
(Years, months, or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town.....
(If outside city or town limits, write "RURAL")

(d) Street No.....
(Street, or location)

(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3. (a) FULL NAME.....

3. (b) If veteran, name war.....

3. (c) Social Security No.....

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month.....day.....year.....hour.....minute.....M.

21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....

that I last saw it alive on ..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death

Due to.....

Due to.....

Due to.....

Duration

10. Usual occupation.....

11. Industry or business.....
(City, town, or county) (State or foreign country)

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

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) Date of death.....
(Month) (Day) (Year)

(b) Date buried.....
(Month) (Day) (Year)

17. Place: (a) Burial, cremation, or removal.....

(b) Place of burial or cremation.....

(c) Name of cemetery or crematory.....

(d) Address.....

18. (a) Signature.....

(b) Date signed.....
(Month) (Day) (Year)

(c) Address.....

19. (a) Name and address of informant.....

(b) Relationship.....

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.....

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.

(Licensed Embalmer's Statement on Reverse Side)

PHYSICIAN

Major findings

Underline the cause to which death is due

Or autopsy

20. If death was due to a violent cause, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

21. Signature.....

Address.....

22. Date received by registrar.....

FOR USE OF LICENSED EMBALMER ONLY

FOR MOTHER ONLY

FOR PHYSICIAN ONLY

FOLDING BACK FOR DATE & REGISTRAL RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. July

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4967

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:
(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)

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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Elizabeth Hoff

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

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

7. Birth date of deceased Mar (Month) 6 (Day) 1892 (Year)

8. AGE: Years 55 Months 2 Days 28 If less than one day hr. min.

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

10. Usual occupation House wife

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

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

19. (a) 7-18-45 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month June Day 4
year 1945 hour minute M.

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

	Duration
Immediate cause of death	
Due to	
Due to	
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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

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

18838