

Registration District No. **42** Primary Registration District No. **1000**

1. PLACE OF DEATH:  
(a) County **Buchanan**  
(b) City or town **St. Joseph**  
(c) Name of hospital or institution **St. Joseph Hosp # 2**  
(If not in hospital or institution, give street number or location)  
(d) Length of stay: In hospital or institution **2**  
(Specify whether years, months or days) **1 yr. 2 mo 4 da**

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo** (b) County **Buchanan**  
(c) City or town **St. Joseph**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **7**  
(If rural, give location)  
(e) Citizen of foreign country? **(Yes or No)**  
If yes, name country

3. (a) PRINT FULL NAME **HARRY HOFFMAN**  
(b) If veteran, name war  
(c) Social Security No.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **June** day **13**  
year **1945** hour **4:10** minute **P** M.

4. Sex **M** 5. Color or race **M**  
6. (a) Single, widowed, married, divorced  
(b) Name of husband or wife **Charl Hoffman**  
(c) Age of husband or wife if alive, years **22**  
7. Birth date of deceased (Month) **Nov** (Day) **22** (Year) **1881**

21. I hereby certify that I attended the deceased from **1945** to **1945**  
that I last saw him alive on **June 13**, 19**45**  
and that death occurred on the date and hour stated above.  
Immediate cause of death **Embolism**  
Duration **Instant**

8. AGE: Years **64** Months **6** Days **21** If less than one day hr. min.

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

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

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

10. Usual occupation **Carpenter**

Major findings: Of operations

11. Industry or business **None**

Of autopsy **72.0**

12. Name **Harry Hoffman**

22. If death was due to external causes, fill in the following:

13. Birthplace **Germany**  
(City, town, or county) (State or foreign country)

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

14. Maiden name **Ellen Hoffman**

(b) Date of occurrence

15. Birthplace **Not known**  
(City, town, or county) (State or foreign country)

(c) Where did injury occur? (City or town) (County) (State)

16. (a) Informant **Cheryl Hoffman**

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

(b) Address **1111 W. 31st St. J.S.**

17. (a) **Burial** (b) Date thereof **June 19, 1945**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **mt. Olivet Cemetery**

18. (a) Signature of funeral director **J. O. Sederbaum**

(b) Address **St. Joseph Mo**

19. (a) **June 18, 1945** (b) **Robert O. Pichler**  
(Date received local registrar) (Registrar's signature)

23. Signature **L. J. Smith** (M. D. or other)

Address **St. Joseph** Date signed **6/18/45**

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

MOTHER FATHER

1946  
JUL 6 700

**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 *Keith Collier*

Licensed Embalmer No. *3632*

P.O. Address *St Joseph*

**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.**