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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. 31981

FILED OCT 25 1945 318

Registration District No. ____ Primary Registration District No. 1003 Registrar's No. 9017

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 St. Anthony's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 Days (Specify whether years, months or days)

In this community ____

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ____

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

(d) Street No. 2739a Utah St.
(If rural, give location)

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

If yes, name country ____

3. (a) PRINT FULL NAME Louise Hoffmann

3. (b) If veteran, name war ____

3. (c) Social Security No. No.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Fred H.

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

7. Birth date of deceased March (Month) 14 (Day) 1880 (Year)

8. AGE: Years 65 Months 7 Days 3 If less than one day ____ hr. ____ min.

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

10. Usual occupation Housewife

11. Industry or business ____

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

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

16. (a) Informant Fred H. Hoffmann
(b) Address 2739a Utah St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 20, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Sunset Burial Park

18. (a) Signature of funeral director Walter Hilderle
(b) Address 3634 Gravois Avenue

19. (a) OCT 19 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 17 year 1945 hour 2 minute 40 A. M.

21. I hereby certify that I attended the deceased from October 13, 45 to Oct. 17, 1945 and that I last saw her alive on Oct. 17, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Apoplexy — Duration 4d.

Due to Hypertensive Heart Disease — 2 yr

Due to Chronic Nephritis — 2 yr

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 George A. Sullivan M.D. (M. D. or other)

Address 421 W. Schirmer Date signed 10/17/45

(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 Robert C Wheeler

Licensed Embalmer No. 2178

P. O. Address St Louis Mo

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.