

FILED NOV 6 1945 STANDARD CERTIFICATE OF DEATH

Registration District No. 366

Primary Registration District No. 6239

Registrar's No. 12

1. PLACE OF DEATH:

(a) County Washington
(b) City or town Rural; Bellevue
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1 mile North of Caledonia
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 45 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Charles Gustus Hoffman

3. (b) If veteran, name war no 3. (c) Social Security No. none

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

6. (b) Name of husband or wife Ruth M. Hoffman 6. (c) Age of husband or wife if alive years

7. Birth date of deceased October 29th 1853
(Month) (Day) (Year)

8. AGE: Years 91 Months 11 Days 8 If less than one day hr. min.

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

10. Usual occupation retired farmer

11. Industry or business

12. Name Charles John Hoffman

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

14. Maiden name Mary Hagen

15. Birthplace Leadwood Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Perry Hoffman

(b) Address Caledonia Mo.

17. (a) burial (b) Date thereof 10-10-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Caledonia Missouri

18. (a) Signature of funeral director Norman White & Sons

(b) Address Ironton Mo.

19. (a) 10-20-45 (b) Olla White
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Washington
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 1 mile north of Caledonia
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 7
year 1945 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from 1940 to 10-2, 1945
that I last saw him alive on 9-23, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death myocarditis

Due to chronic nephritis

Due to old age

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy none

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 U. Buckner (M. D. or other)

Address Deale Mo. Date signed 10-9-45

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

MOTHER FATHER

Duration 5-7
PHYSICIAN
Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 4
District File Number 1145-1252
Date Filed 11-3-45

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 Arcey White
Licensed Embalmer No. 3012
P. O. Address Imperial Missouri

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.