

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. **FILED JAN 31 1946**

Primary Registration District No. **1003**

Registrar's No. **112**

1. PLACE OF DEATH:

(a) County _____

(b) City or town **St. Louis, Missouri**

(c) Name of hospital or institution: **St. Louis City Hospital-Max C. Starkloff**
(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. Louis**

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

(d) Street No. **1712 S. 7th Str.**
Memorial (If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME **DORTHA HOFFMAN**

3. (b) If veteran, name war **No**

3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White**

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

6. (b) Name of husband or wife **Joseph**

6. (c) Age of husband or wife if alive **47** years

7. Birth date of deceased **Dec 25 1903 1904**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

47 **0** **9** hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER { 12. Name **W. W. Tucker**

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

14. Maiden name **Unknown**

15. Birthplace **unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Joseph T. Hoffman**

(b) Address **1712 S. 7th Str.**

17. (a) **Burial** (b) Date thereof **1/7/46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New S. S. Peter & Paul**

18. (a) Signature of funeral director **Wm C. Moydall**

(b) Address **1926 Allen Av.**

19. (a) **JAN 5 1946** (b) **J. J. Bredok**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **4th**
year **1946** hour **12:15** minute **A** M.

21. I hereby certify that I attended the deceased from **12/30/45**
_____ 19____ to **1/4/46** 19____;

that I last saw her alive on **1/4/46** 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death **Hemorrhage from Aortic Aneurysm**

Due to **Syphilis**

Due to **30**

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: **Aneurysm of aorta**

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **J. J. Bredok** **1/4/46** or other) _____
Address _____ Date signed _____

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

2617

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 me

....., Registered Apprentice No.....
working under my personal supervision.

Signed Berg. E. Punsan

Licensed Embalmer No. 2272

P. O. Address 1926 Allen Ave

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.