No. 7
-3-43
-17-39
X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED FEB 5 1946

State File No. 4029

Registration District No. 217 Primary Registration District No. 6676 Registrar's No. 254

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

100844

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town ~~St. Louis~~ Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Villa Gesu Riverview Drive
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96

(c) City or town Valley Park 0
(If outside city or town limits, write "RURAL")

(d) Street No. Ann Ave. 0
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Sister M. Dominica Hoeffler

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 —

6. (b) Name of husband or wife —

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

7. Birth date of deceased May (Month) 13 (Day) 1870 (Year)

8. AGE: Years 75 Months 7 Days 11 If less than one day hr. min.

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

10. Usual occupation Teaching

11. Industry or business Valley Park

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

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

16. (a) Informant Sister M. Theodosia S.S.N.D.

(b) Address 320 East Ripa Ave.

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

(c) Place: burial or cremation Villa Gesu

18. (a) Signature of funeral director Fendler Und Co.

(b) Address 7420 Michigan ave.

19. (a) 1-30-46 (Date received local registrar) (b) E. G. McGarran M.D. (Registrar's signature) MSL

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 24
year 1945 hour minute M.

21. I hereby certify that I attended the deceased from Dec 20 only, 19, to, 1945
that I last saw her alive on Dec 20, 1945;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Pneumonia	5 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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 J. P. Knabb M.D. (M. D. or other)

Address Valley Park Mo Date signed 12-26-46

(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.....V E Morris.....

Licensed Embalmer No. 3360

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.

. No. 2B
M—3-45
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Fiet

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 254

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Rural
(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 Sister M. Dominica Hoeffler

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 S

6. (b) Name of husband or wife

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

7. Birth date of deceased May (Month) 13 (Day) 1878 (Year)

8. AGE: Years 75 Months Days If less than one day hr. min.

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

10. Usual occupation

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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Dec Day 24
year 1944 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.

Immediate cause of death	Duration
Bronchial Pneumonia	5 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED 107

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 F O Knobb MD (M. D. or other)
Address Valley Park Mo Date signed 12-26-45

SUPPLEMENTARY

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

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