

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41994**

FILED JAN 9 1947
Registration District No. **317**

Primary Registration District No. **6076**

Registrar's No. **3429**

1. PLACE OF DEATH:
(a) County ST. LOUIS
(b) City or town MANCHESTER
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: PINE CREST HOMES 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6/30/46
(Specify whether years, months or days) 12/31/46

3. (a) PRINT FULL NAME HOFFMANN MARIE
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex FEMALE race W 5. Color or W
6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased MARCH 15 1861
(Month) (Day) (Year)

8. AGE: Years 85 Months 9 Days 16 If less than one day hr. _____ min. _____

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

10. Usual occupation Nil

MOTHER FATHER
11. Industry or business _____
12. Name unknown
13. Birthplace _____ (City, town, or county) (State or foreign country) 9
14. Maiden name unknown
15. Birthplace _____ (City, town, or county) (State or foreign country) 9

16. (a) Informant See Mother's record
(b) Address De Soto Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-47 (Month) (Day) (Year)
(c) Place: burial or cremation De Soto

18. (a) Signature of funeral director See Mother's record
(b) Address _____

19. (a) 1-2-47 (Date received local registrar) (b) Ruth Allen (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County 50
(c) City or town DE SOTA MO (If outside city or town limits, write "RURAL") 2
(d) Street No. _____ (If rural, give location) 2
(e) Citizen of foreign country? _____ (Yes or No) 1
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DECEMBER day 31 year 1946 hour 5 minute AM
21. I hereby certify that I attended the deceased from December 23rd, 1946 to December 31, 1946 that I last saw her alive on December 30, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia Duration _____

Due to _____
Due to 93D

Other conditions Chronic Myocarditis
(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? _____

While at work? _____ (Specify type of place) (e) Means of injury 11

23. Signature R. H. Jensen (M. D. or other) _____
Address Manchester Mo Date signed 12/31/46

JAN 29 1947

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

[Handwritten Signature]
.....
Licensed Embalmer No. 3531
P. O. Address *[Handwritten Address]*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

41994-46
Jan
3629

Registration District No. 317

Primary Registration District No. 6076

1. PLACE OF DEATH: ST. LOUIS

(a) County.....

(b) City or town..... Manchester
(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
years, months or days).....

3. (a) PRINT FULL NAME Marie Hoffman

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, W

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

7. Birth date of deceased Mar 15
(Month) (Day) (Year)

8. AGE: Years 85 Months Days If less than one day hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

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

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) Ruth J. Allen (Registrar's signature)

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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to..... 19..... that I last saw h..... alive on..... and that death occurred on the date and hour stated above. Immediate cause of death.....

Duration

Due to.....

Due to.....

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?

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

23. Signature..... (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTARY

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

