

FILED JAN 17 1947

Registration District No. 199

Primary Registration District No. 1002

Registrar's No. 9

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Nauvoo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Lakeside Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 months
(Specify whether years, months or days)

In this community 3 months

2. USUAL RESIDENCE OF DECEASED:

(a) State Wisconsin (b) County 99

(c) City or town Milwaukee (If outside city or town limits, write "RURAL") 47

(d) Street No. 115 E. Menasha Ave
(If rural, give location) 0

(e) Citizen of foreign country? NO (Yes or No) 2

If yes, name country _____

3. (a) PATIENT FULL NAME Walter A. Hoffmann

3. (b) If veteran, name war no

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 2
year 47 hour 7 minute 47 A.M.

21. I hereby certify that I attended the deceased from out
1946 to 1-2, 1947
that I last saw him alive on 1-2-47
and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race wh

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

6. (b) Name of husband or wife Mae

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased April 18 - 1888
(Month) (Day) (Year)

Immediate cause of death Myocardial failure

Due to Typhimexia

8. AGE: Years 58 Months 8 Days 15
If less than one day hr. _____ min. _____

Due to Chronic Cholelithiasis and Cholelithropia

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

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

10. Usual occupation Telepathy Physician

Major findings: Chronic fibrosis of bile ducts, presence of Cholelithiasis

Of autopsy Cholelithiasis and chronic cholelithropia

22. If death was due to external causes, fill in the following:

MOTHER FATHER

11. Industry or business _____

12. Name Mary Hoffmann

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

14. Maiden name Bertha Row

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

(a) Accident, suicide, or homicide (specify) _____

(b) Where did injury occur? _____
(City or town) (County) (State)

(c) Did injury occur in or about home, on farm, in industrial place, in public place? _____

16. (a) Informant Mae Walter Hoffmann

(b) Address 115 E. Menasha Ave. Milwaukee

17. (a) removal (b) Date thereof 1-3-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Milwaukee Wisconsin

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place)

While at work? _____ (c) Means of injury _____

18. (a) Signature of funeral director L. J. Walter

(b) Address Kansas City Mo.

19. (a) 1-3-47 (b) Gertrude Holmes
(Date received local registrar) (Registrar's signature)

23. Signature Wm. J. Jumper (M. D. or other) W

Address 303 E. Washington Date signed 1-3-47

Duration
36 hours
48 hours

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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 *J. S. Walton*.....

Licensed Embalmer No.....

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.