

No. 2
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-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10990**
Registrar's No. **3616**

FILED APR 14 1947
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis, Missouri
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 8123 Ivory Ave.,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 117
(d) Street No. 8123 Ivory Ave., (If rural, give location) 9
(e) Citizen of foreign country? _____ (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Katherine Hoffmann

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced. Married

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

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

8. AGE: Years Months Days If less than one day
68 9 20 _____ hr. _____ min.

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

10. Usual occupation None

11. Industry or business _____

12. Name John Engler

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

14. Maiden name Unknown

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

16. (a) Informant Mr. Frank Hoffmann

(b) Address 8123 Ivory Ave.,

17. (a) Burial (b) Date thereof 4-7-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park Lawn Cemetery

18. (a) Signature of funeral director _____

(b) Address 6322 S. Grand

19. (a) APR 5 1947 (b) J. F. Bredeek
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 3rd
year 1947 hour 11 minute 40 a.m.

21. I hereby certify that I attended the deceased from Jan 8 1945 to April 3 1947
that I last saw him alive on April 2 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis Duration Chronic
Arteriosclerosis Chronic

Due to _____
Due to _____
Other conditions Acute Bronchitis 10 days
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy 93
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 [Signature] (M. D. or other) 0
Address 7749 Date signed 4/4/47

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. Wm Bentley
Licensed Embalmer No. 3657
P. O. Address St Louis Mo

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.