

Registration District No. 318

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County MO.
(b) City or town St. Louis
(c) Name of hospital or institution: St. John's Hosp.
(d) Length of stay: In hospital or institution 15 min.
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County MO.
(c) City or town St. Louis
(d) Street No. 4165 Walsh St.
(e) Citizen of foreign country? No
If yes, name country

3. (a) PRINT FULL NAME Mary Rose Hoffmann

3. (b) If veteran, name war No. (c) Social Security No.

4. Sex Female 5. Color or race W. 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased 5-3-47
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day 1 hr. 20 min.

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

10. Usual occupation

11. Industry or business

12. Name John Hoffmann

13. Birthplace St. Louis, MO.

14. Maiden name Catherine Satter

15. Birthplace Baltimore, Maryland

16. (a) Informant MR. JOHN N. HOFFMANN

(b) Address 4165 WALSH

17. (a) BURIAL (b) Date thereof 5-5-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation OLD SS PETER & PAUL CH.
18. (a) Signature of funeral director SOUTHERN FUNERAL HOME
(b) Address 6322 S. GRAND BLVD.
MAY 5 1947
19. (a) (Date received local registrar) 7 (Registrar's signature) J. A. Brebeck

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 3 year 47 hour 9 minute 20 P.M.

21. I hereby certify that I attended the deceased from 8:19 PM 5-3-47 to 9:20 PM 5-3 1947
that I last saw her alive on 5-3-47 @ 9:20 pm 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Premature Smog
Due to 15 min.
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 0
Of autopsy 0

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) 0
(b) Date of occurrence 0
(c) Where did injury occur? (City or town) (County) (State) 0
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 0

While at work? (Specify type of place) (e) Means of injury 0
23. Signature Joseph M. Greb (M. D. or other) MD
Address 4165 Walsh St. St. Louis, Mo. Date dictated 5-3-47

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1857

Not embalmed

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.....

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.