

No. 2
5-43
5-17-39
I X36671

FILED JUN 9 1947

Registration District No. **87** Primary Registration District No. **5324** Registrar's No. **11**

1. PLACE OF DEATH:

(a) County **Crowford Boone**

(b) City or town **BAURBON "RURAL"**

(c) Name of hospital or institution: **NO 3**

(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)

In this community (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Boone**

(c) City or town **St Louis University City**

(d) Street No. **7909 Leasdale St**

(If rural, give location)

(e) Citizen of foreign country? (Yes or No) **1**

If yes, name country

3. (a) PRINT FULL NAME **BERNARD VON HOFFMAN**

3. (b) If veteran, name war **W. W. II**

3. (c) Social Security No. **488-01-7060**

4. Sex **MO** 5. Color or race **W**

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

6. (b) Name of husband or wife **Dorothy McClinton**

6. (c) Age of husband or wife if alive **43** years

7. Birth date of deceased **11-3-1900**

(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **31** year **1947** hour **7** minute **5** M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

8. AGE: **46** Years **6** Months **28** Days If less than one day hr. min.

9. Birthplace **Milwaukee Wis-1**

(City, town, or county) (State or foreign country)

10. Usual occupation **Executive**

11. Industry or business **Printing**

12. Name **Albert Von Hoffman**

13. Birthplace **Vienna Austria**

(City, town, or county) (State or foreign country)

14. Maiden name **ALBRECHT**

15. Birthplace **Staten Island N.Y.**

(City, town, or county) (State or foreign country)

16. (a) Informant **J. S. Alderson**

(b) Address **Jefferson City, Mo.**

17. (a) **Reburied** (b) Date of reburial **6-1-47**

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Spring Mo.**

18. (a) Signature of funeral director **Edging**

(b) Address **6-1-47**

19. (a) **6-1-47** (b) **Edging**

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

Due to **New Plain Accident**

Due to **Concussion**

Other conditions (Include pregnancy within 3 months of death) **1938**

Major findings: **Jury verdict**

Of operations _____

Of autopsy _____

Duration _____

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) **Accident**

(b) Date of occurrence **5-31-1947**

(c) Where did injury occur **Bourbon Crowford Mo**

(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? (a) Means of injury **Truck**

23. Signature **Henry M. Alderson** (b) **Edging**

(Signature) (Name or other)

Address **St. Louis Mo** Date signed **6/1/47**

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

MOTHER FATHER

JUN 10 1947

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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.....

Dorman O Hoener

Registered Apprentice No. *445*

working under my personal supervision.

Signed *Albert E Long*

Licensed Embalmer No. *3504*

P. O. Address *Courbon 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.