

FILED OCT 6 1947
Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 853

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

1. PLACE OF DEATH:

(a) County Greene

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

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

(d) Length of stay: In hospital or institution 8 days
(Specify whether years, months or days)

In this community 74 years

3. (a) PRINT FULL NAME AMAZORA HOFFMAN

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 Max Hoffman

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

7. Birth date of deceased October 30, 1872
(Month) (Day) (Year)

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

74 10 28 hr. min.

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

10. Usual occupation Housewife

11. Industry or business Home Makeing

12. Name Jacob Hinkle

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

14. Maiden name Unknown

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

16. (a) Informant Max Hoffman (Husband)

(b) Address Willard, Missouri (Route # 1)

17. (a) Burial (b) Date thereof 9/29/1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rose Hill Cemetery

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home

(b) Address Springfield, Missouri

19. (a) 9-29-47 (b) W. J. Gaudy MD
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

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

(d) Street No. RURAL ROUTE # ONE (1)
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 27,
year 1947 hour 4: minute 20 P. M.

21. I hereby certify that I attended the deceased from 9-1-1947 to 9-27-1947
that I last saw him alive on 9-27-1947
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic heart disease - coronary arteriosclerosis
Gen Sensitivity

Due to _____

Due to _____

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

Major findings: —

Of operations —

Of autopsy no

Duration _____

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 trauma) _____
Means of injury —

23. Signature W. J. Gaudy MD (M. D. or other) _____
Address Springfield, Missouri Date signed 9-29-47

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 479

Harry Kypse, Registered Apprentice No. _____,
working under my personal supervision

Signed Jewell E. Kudd

Licensed Embalmer No. 2831

P. O. Address Springfield 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.