

X47070

FILED SEP 18 1947
310

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32227
State File No. _____
Registrar's No. 154

Registration District No. _____

Primary Registration District No. 6051

1. PLACE OF DEATH:

(a) County St. Charles
(b) City or town St. Charles
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Charles County Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 months
(Specify whether years, months or days)

3. (a) PRINT FULL NAME James Hoffmann

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

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

6. (b) Name of husband or wife Anna Hoffman
6. (c) Age of husband or wife if alive years

7. Birth date of deceased October 31 1861
(Month) (Day) (Year)

8. AGE: Years 85 Months 10 Days 25
If less than one day hr. min.

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

10. Usual occupation laborer

11. Industry or business _____

12. Name George Hoffman

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

14. Maiden name Susana Jamison

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

16. (a) Informant Rev. Wm G. Pezold

(b) Address Cottleville, Missouri

17. (a) burial (b) Date thereof Aug 28-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Joseph Cem Cottleville, Mo.

18. (a) Signature of funeral director H. L. Dallmeier & Sons

(b) Address 800 N. 2nd-St. Charles, Mo.

19. (a) 8/31/47 (b) F. A. ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Charles
(c) City or town Cottleville
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 25
year 1947 hour 2:00 minute _____ P. M.

21. I hereby certify that I attended the deceased from Aug 25 1947
that I last saw him alive on 21 Aug 1947
and that death occurred on the date and hour stated above.

Immediate cause of death myocarditis
Duration 5 yrs

Due to generalized arteriosclerosis 15 yrs.

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

Major findings: Of operations _____
Of autopsy _____
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)
(c) Means of injury _____

23. Signature F. A. ... MD (M. D. or other)
Address D. F. ... Date signed 26 Aug 47

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

002

~~Date Filed SEP 17 1947~~

~~District File Number~~

District Health Officer No. 9,

RECEIVED

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 *Joseph F. Lander*

Licensed Embalmer No. *4189*

P. O. Address *St Charles*

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.