

No. 300
-10-47
-17-39
-3905

77-02104

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 6502
Registrar's No. 1461

FILED FEB 20 1948
318

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.....

(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:
St. Louis City Hospital - Max C. Starkloff
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
(Specify whether

In this community.....
years, months or days)

3. (a) PRINT FULL NAME JOSEPH HOFFMANN

3. (b) If veteran, name war.....

3. (c) Social Security No.

4. Sex Male Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Josephine G. Hoffmann

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

7. Birth date of deceased November 17-1862
(Month) (Day) (Year)

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

85 2 24 hr. min.

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

10. Usual occupation Bill

11. Industry or business.....

MOTHER FATHER

12. Name George Hoffmann

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

14. Maiden name Mary Hannibal

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

16. (a) Informant Joseph Hoffmann, son

(b) Address 4493 Bircher Bl.

17. (a) burial (b) Date thereof 2-13-1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Harrigan & Sheahan

(b) Address 4415 Washington Bl.

19. (a) FEB, 2 1948 (b) J. J. Bredbeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 25 1719 O'Fallon St.
Memorial (If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 10th
year 1948 hour 11 minute 15 P.M.

21. I hereby certify that I attended the deceased from 2/5/48
....., 19..... to Feb. 10th, 19 48
and that death occurred on the date and hour stated above.

that I last saw him alive on Feb. 10th, 19 48

Immediate cause of death Bronchopneumonia

Duration 1 wk

Due to Congestive Heart Failure

Due to Coronary Arteriosclerosis

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

Major findings: PH

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)

(e) Means of injury John Murphy

23. Signature John Murphy 2/11/48 (other)
1515 Lafayette Date signed

Address.....

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. Allen Davis*

Licensed Embalmer No..... *40531*

P. O. Address..... *W. Ave*

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.

No. 2B
3-45
K43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. March
Registrar's No. 1461

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME Joseph Hoffman

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

4. Sex m Color of race w

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

7. Birth date of deceased.....
(Month) (Day) (Year)

8. AGE: Years 85 Months 2 Days 20 If less than one day
hr. min.

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

10. Usual occupation supervisor

MOTHER FATHER

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March Year 1978 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 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.....

Duration

Due to.....

Due to.....

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

PHYSICIAN

Major findings:
Of operations.....

Of autopsy.....

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..... (M. D. or other)

Address..... Date signed.....

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

SUPPLEMENTARY

MAR 2 1978

1948

S-6502

82-9068