S. No. 2
M—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6540

FILED MAR 11 1948

Registration District No. 818 — Primary Registration District No. 1003 — Registrar's No. 2145

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

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: 6279 Reber Pl.
(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
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County aaa

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 3 6279 Reber Pl. 9
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME CATHERINE (KATIE) FRANCES JOFFRAY

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Louis Joffray

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

7. Birth date of deceased July (Month) 26 (Day) 1872 (Year)

8. AGE: Years 75 Months 7 Days 2 If less than one day hr. min.

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

10. Usual occupation Nil

11. Industry or business

FATHER
12. Name William Cocoran 0
13. Birthplace St. Louis (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name Catherine Mueller 5
15. Birthplace (City, town, or county) Switzerland (State or foreign country)

16. (a) Informant Mrs Olive C. Krone
(b) Address 7237 West Park

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 1 1948 (Month) (Day) (Year)
(c) Place: burial or cremation Lakewood Park Cem.

18. (a) Signature of funeral director C. Hoffmeister Colonial Mortuary
(b) Address 6464 Chippewa St.

19. MAR 2 1948 (Date received local registrar) (b) J. F. Bradack (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 28
year 1948 hour 12 minute 10 P M.

21. I hereby certify that I attended the deceased from 1941 19 to 2/28/48 19
that I last saw her alive on 2/28/48 19
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	6 days
Due to Generalized arteriosclerosis	yes
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations None
Of autopsy None

PHYSICIAN
Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) no
(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? (Specify type of place)
While at work (e) Means of injury 0

23. Signature John A. Mann Mil (M. D. or other)
Address 2648 Oakview Date signed 2/28/48

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

Dr. J. R. Briscoe
2648 Oakview Tr.

2145

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 Harry J Schumacher

Licensed Embalmer No. 2679

P. O. Address 7514 S. Broadway

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.