

FILED FEB 15 1949

STANDARD CERTIFICATE OF DEATH

State File No. 2331

BIRTH NO. _____ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 32

929

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

1. PLACE OF DEATH a. COUNTY <u>ST. CHARLES</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. CHARLES</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>ST. CHARLES</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>ST. CHARLES</u>	
c. LENGTH OF STAY (In this place) <u>2 WEEKS</u>		d. STREET ADDRESS (If rural, give location) <u>ST. JOSEPH HOME</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>ST. JOSEPHS HOSP.</u>			
3. NAME OF DECEASED (Type or Print) <u>Stephen</u>		a. (First) <u>Stephen</u> b. (Middle) _____ c. (Last) <u>Hoffmann</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>12-26-1881</u>	
9. AGE (In years last birthday) <u>67</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STONE MOLDER</u>	
11. BIRTHPLACE (State or foreign country) <u>AUSTRIA</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <u>MATTHEW HOFFMAN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
14. NAME OF HUSBAND OR WIFE <u>MARIE HOFFMAN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>499-26-2339</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>MRS E. DISTLERATH. 1709 McLARAN</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			
MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary infarction -</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 hours</u>	
ANTECEDENT CAUSES			
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>Portal thrombosis</u>	
DUE TO (c) <u>Islet cell tumors of Pancreas</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>Jan 25 '49</u>		19b. MAJOR FINDINGS OF OPERATION <u>Islet cell tumors of Pancreas</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>Jan 23, 1949</u> to <u>Feb 6, 1949</u> , that I last saw the deceased alive on <u>Jan 5, 1949</u> and that death occurred at <u>7:40 Am.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>J. A. Schneider</u>		23b. ADDRESS <u>207 W. 5th - St. Charles, Mo</u>	
23c. DATE SIGNED <u>2/10/49</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
24b. DATE <u>2/9/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>CALVARY</u>	
24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS, MO</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. Wood, 2117 E. GRAND</u>	
DATE REC'D BY LOCAL REG. <u>2-8-49</u>		REGISTRAR'S SIGNATURE <u>Fannie Hamilton</u>	

Date filed FEB 14 1949

District No. 10

District Health Commission No. 5

RECEIVED

FEB 14 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Frank W Moore*

Licensed Embalmer No. *3041*

P. O. Address *2117 E Grand*

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.