

FILED FEB 24 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

4464

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 116 PRIMARY REG. DIST. No. 3020 Registrar's No. 34

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before institution). a. STATE <u>Missouri</u> b. COUNTY <u>Franklin</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Washington</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Washington Mo.</u>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>304 W 5th Street 1</u>		<u>304 W 5th St 2</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>CLARA</u>	b. (Middle) <u>EMMA</u>	c. (Last) <u>HOFFMANN</u>	4. DATE OF DEATH (Month) (Day) (Year)
				<u>Feb. - 16 - 1949</u>

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>	8. DATE OF BIRTH <u>Mar. 27 - 1872</u>	9. AGE (In years last birthday) <u>76</u>	# UNDER 1 YEAR Months <u>10</u> Days <u>19</u>	# UNDER 1 MTH. Hours <u>-</u> Min. <u>-</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Washington Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>Robert Hoffmann</u>	13b. MOTHER'S MAIDEN NAME <u>Julia Strumpf</u>	14. NAME OF HUSBAND OR WIFE <u>none</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	(If yes, give war or dates of service) <u>none</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Robert Hoffmann</u>	ADDRESS <u>Washington Mo</u>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Paget's disease of the bow</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>93ix</u>		

19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION <u>none</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from 23 Aug, 1948, to 16 Feb, 1949, that I last saw the deceased alive on 15 Feb, 1949, and that death occurred at 9:30 am., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Raymond J. Boyce, M.D.</u>	23b. ADDRESS <u>Washington Mo.</u>	23c. DATE SIGNED <u>17 Feb 19</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Feb 18 - 49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellow</u>	24d. LOCATION (City, town, or county) (State) <u>Washington Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Feb. 17, 1949</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>	ADDRESS <u>Washington Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

36  
6  
2

APR 14 1950

RECEIVED  
District Health Officer No. 9,  
FEB 23 1949  
Date Filed

AUG 30 1956

**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.

Signed \_\_\_\_\_



Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 2464

P. O. Address Washington 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.