

FILED AUG 4 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24081

63
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BIRTH NO. _____ REG. DIST. NO. 207 PRIMARY REG. DIST. NO. 2727 Registrar's No. 21

1. PLACE OF DEATH a. COUNTY Maries		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Maries	
b. CITY (If outside corporate limits, write RURAL and give township) Rural (Jefferson Twn.)		c. CITY (If outside corporate limits, write RURAL and give township) Rural (Jefferson Twn.)	
c. LENGTH OF STAY in this place 50 yrs		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED a. (First) Ina		b. (Middle)	
c. (Last) Hoffarth		4. DATE OF DEATH (Month) (Day) (Year) July 23-49	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 19-1885
9. AGE (In years last birthday) 63		10. MONTHS 8	11. DAYS 5
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Jona Simon		13b. MOTHER'S MAIDEN NAME Mary Garrell	14. NAME OF HUSBAND OR WIFE Oscar Hoffarth
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Oscar Hoffarth
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 INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer Cervix Uteri		ANTECEDENT CAUSES	
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.		174X	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION None		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) no	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) no	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) no	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) no	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? no	
22. I hereby certify that I attended the deceased from July 1, 1949 to July 25, 1949 , that I last saw the deceased alive on July 23, 1949 , and that death occurred at 10:30 P.M. from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) H. D. Jones M.D.		23b. ADDRESS Belle	23c. DATE SIGNED July 24
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE July 25-49	24c. NAME OF CEMETERY OR CREMATORY Grove Dale Cemetery	24d. LOCATION (City, town, or county) (State) Maries County-Mo.
DATE REC'D BY LOCAL REG. 7-30-49	REGISTRAR'S SIGNATURE Pauline Howard	FUNERAL DIRECTOR'S SIGNATURE Chas. Sassen	ADDRESS Funeral Service Belle

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

RECEIVED
AUG 2 1919
District Health Officer No. 9,
District File Number

AUG 4 1919

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 Chester Deseaman

Signed _____
Student Embalmer

Licensed Embalmer No. 4178

P. O. Address Island - 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.