

FILED JUL 30 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24903

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1003

State File No. 6311
Registrar's No. 6311

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. 6311		Registrar's No. 6311				
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____								
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis Missouri</u>			c. LENGTH OF STAY (in this place) <u>15 Yrs</u>			c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Louis</u>						
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3235a Missouri Av</u>				d. STREET ADDRESS (If rural, give location) <u>29- 3235a Missouri Av</u>								
3. NAME OF DECEASED (Type or Print) a. (First) <u>George</u>		b. (Middle) <u>Karl</u>		c. (Last) <u>Hoffmann</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 17th 1949</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>		8. DATE OF BIRTH <u>Oct. 20 1882</u>		9. AGE (In years last birthday) <u>66</u>		IF UNDER 1 YEAR Months <u>8</u>	IF UNDER 12 HRS. Hours <u>27</u>	IF UNDER 15 MIN. Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Food Market</u>			11. BIRTHPLACE (State or foreign country) <u>St. Louis Mo</u>			12. CITIZEN OF WHAT COUNTRY? _____			
13a. FATHER'S NAME <u>George W Hoffmann</u>				13b. MOTHER'S MAIDEN NAME <u>Bertha Schaaf</u>				14. NAME OF HUSBAND OR WIFE *****				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. <u>497-01-3775</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Hilda Hoffmann</u>				ADDRESS <u>3235 Missouri</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 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hodgkins disease</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____ 11. OTHER SIGNIFICANT CONDITIONS <u>cardiac degeneration</u> Conditions contributing to the death but not related to the disease or condition causing death.								INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>10 da</u>		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____								20. AUTOPSY? -YES <input type="checkbox"/> NO <input 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? <u>201X</u>							
22. I hereby certify that I attended the deceased from <u>July 6, 1949</u> , to <u>July 12, 1949</u> , that I last saw the deceased alive on <u>July 15, 1949</u> , and that death occurred at <u>7 P. m.</u> , from the causes and on the date stated above.												
23a. SIGNATURE <u>Walter G. Abell</u> (Degree or title) <u>McR</u>				23b. ADDRESS <u>2253 So 39th</u>				23c. DATE SIGNED <u>7/19/49</u>				
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>July 21 49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>New St Marcus Cem</u>			24d. LOCATION (City, town, or county) (State) <u>St Louis Mo</u>					
DATE REC'D BY LOCAL REG. <u>JUL 20 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Lasater</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>Weick Bros Funeral Home</u>			ADDRESS <u>2201 So. Grand</u>				

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

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 _____

William S. Salfer Student Embalmer No. _____
working under my personal supervision.

Signed William S. Salfer
Student Embalmer

Signed Donald Yohike
Licensed Embalmer No. 3917
P. O. Address St. Louis

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.