

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25989

State File No. \_\_\_\_\_

FILED AUG 24 1949

5907

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. \_\_\_\_\_ Registrar's No. 237

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Adair</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b> b. COUNTY <b>Adair</b> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>R. R. #3 Kirksville, Mo.</b> |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kirksville</b>  |  |
| c. LENGTH OF STAY (in this place) <b>14 yrs</b>  |  | d. STREET ADDRESS (If rural, give location) <b>R. R. #3</b>   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>R. R. #3, Kirksville, Mo</b>                                      |  |   |  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>Victor</b> b. (Middle) <b>Francis</b> c. (Last) <b>Hoffman</b> |  |   | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>Aug 9 1949</b> |   |  |
| 5. SEX <b>Male</b>  |  | 6. COLOR OR RACE <b>White</b>                   |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b> |  |
| 8. DATE OF BIRTH <b>Sept. 19, 1893</b>  |  | 9. AGE (In years last birthday) <b>55</b>       |  | IF UNDER 1 YEAR Months Days IF UNDER 1 HR. Hours Min.                 |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                         |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b> |  | 11. BIRTHPLACE (State or foreign country) <b>Schuyler County, Mo.</b> |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.S.</b>  |  |   |  |   |  |

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 13a. FATHER'S NAME <b>Martin Hoffman</b> |  | 13b. MOTHER'S MAIDEN NAME <b>Elberta Tarr</b> |  | 14. NAME OF HUSBAND OR WIFE <b>Florence Elms</b> |  |
|--|--|---|--|--|--|

|  |  |                                     |  |  |  |
|--|--|-------------------------------------|--|--|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b> |  | 16. SOCIAL SECURITY NO. <b>None</b> |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Florence Hoffman, Kirksville</b> |  |
|--|--|-------------------------------------|--|--|--|

|  |  |  |  |  |   |  |
|--|--|--|--|--|---|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)   |  | MEDICAL CERTIFICATION  |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b> |  |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>apoplexy</b>   |  | ANTECEDENT CAUSES DUE TO (b) <b>Arteriosclerosis</b>   |  |  | DUE TO (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. |  | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Arteriosclerosis</b> |  |  | <b>334X</b>                                     |  |

|                        |  |                                  |  |  |   |  |
|------------------------|--|----------------------------------|--|--|---|--|
| 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                       |  |

22. I hereby certify that I attended the deceased from July 1, 1949 to Aug 9, 1949 that I last saw the deceased alive on Aug 9, 1949, and that death occurred at 4 P.M., from the causes and on the date stated above.

|   |  |                                   |  |                                  |  |
|---|--|-----------------------------------|--|----------------------------------|--|
| 23a. SIGNATURE (Degree or title) <b>C. L. Martin D.O.</b> |  | 23b. ADDRESS <b>Kirksville Mo</b> |  | 23c. DATE SIGNED <b>Aug 9-49</b> |  |
|---|--|-----------------------------------|--|----------------------------------|--|

|   |  |                          |  |   |  |  |  |
|---|--|--------------------------|--|---|--|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> |  | 24b. DATE <b>8/11/49</b> |  | 24c. NAME OF CEMETERY OR CREMATORY <b>Maple Hills</b> |  | 24d. LOCATION (City, town, or county) (State) <b>Kirksville, Mo.</b> |  |
|---|--|--------------------------|--|---|--|--|--|

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| DATE REC'D BY LOCAL REG. <b>8-13-49</b> |  | REGISTRAR'S SIGNATURE <b>Kate Lambert</b> |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Paul Riley Kirksville, Mo.</b> |  |
|---|--|---|--|--|--|

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED AUG 22 1949  
District Health Officer No. 10  
District File Number 8-49-142  
Date Filed AUG 22 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.....

*Roy H. Mercer Jr*

Licensed Embalmer No. 4432

P. O. Address Kirkville, 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.