

FILED NOV 21 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

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

38830

9678

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1002</b>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MO</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town or township) <b>ST LOUIS</b>		c. LENGTH OF STAY (in this place) <b>0</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>ST LOUIS</b>		d. STREET ADDRESS (If rural, give location) <b>5622 Milentz</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>JOSEPHINE HEITKAMP HOSP</b>				d. STREET ADDRESS (If rural, give location) <b>5622 Milentz</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>FREDERICH</b>			b. (Middle) <b>HENRY</b>		c. (Last) <b>HOFFMEISTER</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>NOV 7-1949</b>
5. SEX <b>M U W</b>	6. COLOR OR RACE _____	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>JULY 14-1874</b>		9. AGE (In years last birthday) <b>75</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>		11. BIRTHPLACE (State or foreign country) <b>House Springs MO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>PETER HENRY HOFFMEISTER</b>			13b. MOTHER'S MAIDEN NAME <b>HARTHKE</b>		14. NAME OF HUSBAND OR WIFE <b>CLARA NOLLMAN</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT'S SIGNATURE OR NAME <b>John Hoffmeister</b>		ADDRESS _____	
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.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>MESENTERIC THROMBOSIS</b>						INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES DUE TO (b) <b>ACUTE INTESTINAL OBSTRUCTION</b>						<b>1 wk</b>
	DUE TO (c) _____						
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						
19a. DATE OF OPERATION <b>11/7/49</b>		19b. MAJOR FINDINGS OF OPERATION <b>ACUTE INTESTINAL OBSTRUCTION MESENTERIC THROMBOSIS</b>				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) <b>79</b>			
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? <b>5-7-12</b>			
22. I hereby certify that I attended the deceased from <b>Nov 6, 1949</b> , to <b>Nov 7, 1949</b> , that I last saw the deceased alive on <b>Nov 7, 1949</b> , and that death occurred at <b>11:30 p.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>John Hoffmeister MD</b>				23b. ADDRESS <b>1504 So Grand</b>		23c. DATE SIGNED <b>11/8/49</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>11-8-49</b>	24c. NAME OF CEMETERY OR CREMATORY <b>St Martin's Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>High Ridge MO</b>		
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>NOV 10 1949</b>		REGISTRAR'S SIGNATURE <b>J. B. Sander</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>John Hoffmeister House Springs MO</b>			

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

8296

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 *Van M. Seymour*

Licensed Embalmer No. *4343*

P. O. Address *St. Louis, 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.