

FILED NOV 21 1949

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 39773

96

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

BIRTH NO.		REG. DIST. NO. 317	PRIMARY REG. DIST. NO. 6076	Registrar's No. 4297
1. PLACE OF DEATH a. COUNTY St Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Mo b. COUNTY St Louis		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Manchester		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		
c. LENGTH OF STAY (In this place) 6 mo		d. STREET ADDRESS (If rural, give location) 112 No 6th		
d. FULL NAME OF HOSPITAL OR INSTITUTION Pine Crest Nursing Home				
3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) C c. (Last) Hoffman		4. DATE OF DEATH (Month) (Day) (Year) 10-30-1949		
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Unknown	8. DATE OF BIRTH 8-1-1871	
9. AGE (In years last birthday) 78		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		11. BIRTHPLACE (State or foreign country) Unknown
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? Unknown
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Unknown
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. 499-03-8045		17. INFORMANT'S SIGNATURE OR NAME Pine Crest Nursing Home ADDRESS Manchester Mo
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) Ch Myocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) Cerebral Hemorrhage 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		19b. MAJOR FINDINGS OF OPERATION		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) 331X
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		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 4-22 1949, to 10-30, 1949, that I last saw the deceased alive on Oct 24, 1949, and that death occurred at 7:45 a.m., from the causes and on the date stated above.				
23a. SIGNATURE A. P. Murlin M.D.		23b. ADDRESS (Degree or title) 3507 Potomac		23c. DATE SIGNED 10-31-49
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 11-3-1949		24c. NAME OF CEMETERY OR CREMATORIUM anatomical board
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S NAME AND ADDRESS Rowland Mortuary Service Inc. 4104 Manchester Ave. St. Louis 10, Mo.		
DATE REC'D BY LOCAL REG. Nov. 2, 1949		REGISTRAR'S SIGNATURE Herbert R. Drake M.D.		

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.