

FILED AUG 7 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23295

396

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 667A

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield	
c. LENGTH OF STAY (In this place) 42 Yrs		d. STREET ADDRESS (If rural, give location) 706 McCann	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John Hosp.			

3. NAME OF DECEASED (Type or Print)	a. (First) Lee	b. (Middle) R.	c. (Last) Hoff	4. DATE OF DEATH (Month) (Day) (Year) July 27, 1950
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 2 1883	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work (If more than one, list all in order of importance)) Assist to Sup. Insp.	10b. KIND OF BUSINESS OR INDUSTRY Frisco R.R.	11. BIRTHPLACE (State or foreign country) Sedalia, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Charles Hoff	13b. MOTHER'S MAIDEN NAME Amy	14. NAME OF HUSBAND OR WIFE Minnie M. Hoff
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. ?	17. INFORMANT'S SIGNATURE OR NAME Mrs. Minnie Hoff ADDRESS Springfield, Mo.
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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 Years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Emphysema and asthma DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		4 2/3	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **6-30** ^{10:50} to **7-27**, 19**50**, that I last saw the deceased alive on **7-27**, 19**50**, and that death occurred at **1:30p** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Homer C. Marshall, M.D.	23b. ADDRESS Prof. Bldg. Springfield	23c. DATE SIGNED 7-31-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE July 29, 50	24c. NAME OF CEMETERY OR CREMATORY Maple Park	24d. LOCATION (City, town, or county) (State) Springfield, Mo.
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DATE REC'D BY LOCAL REG. 8-2-50	REGISTRAR'S SIGNATURE W E Haudy	25. FUNERAL DIRECTOR'S SIGNATURE H.H. Lohmeyer ADDRESS Springfield, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

APR 29 1950

APR 7 1950

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 Walter E. Hamel

Signed _____
Student Embalmer

Licensed Embalmer No. 3808

P. O. Address Springfield 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.