

FILED AUG 31 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 27386

BIRTH NO. _____		REG. DIST. NO. 174		PRIMARY REG. DIST. NO. 3035		Registrar's No. 62	
1. PLACE OF DEATH a. COUNTY Lafayette				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Lafayette			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lexington		c. LENGTH OF STAY (In this place) over 30 yrs.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lexington		1542	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1824 Franklin				d. STREET ADDRESS (If rural, give location) 1824 Franklin			
3. NAME OF DECEASED (Type or Print) KATHERINE		a. (First)		b. (Middle) BLEE		c. (Last) HOFFMAN	
4. DATE OF DEATH July 23, 1950		5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH June 7, 1888		9. AGE (In years last birthday) 62		10. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Lexington, Mo.	
12. CITIZENRY OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Harry Blee		13b. MOTHER'S MAIDEN NAME Elizabeth O'Brien		14. NAME OF HUSBAND OR WIFE Ernest W. Hoffman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Ernest W. Hoffman, Lex., Mo. 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) Rupture Aortic Aneurysm ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis Sclerotic? 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)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	
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 5/1/50, 1950 to 7/23, 1950, that I last saw the deceased alive on _____, 19____, and that death occurred at 10:00 AM on the causes and on the date stated above.							
23a. SIGNATURE [Signature] (Degree or title)				23b. ADDRESS Lexington Mo.		23c. DATE SIGNED 7/24/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 7/25/50		24c. NAME OF CEMETERY OR CREMATORY Memorial Park		24d. LOCATION (City, town, or county) (State) Lexington, Mo.	
DATE REC'D BY LOCAL REG. Aug 10, 1950		REGISTRAR'S SIGNATURE [Signature]		156 FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS Lexington, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 8/30/50  
DISTRICT HEALTH OFFICE No. 3  
District File Number \_\_\_\_\_  
Date Filed 8/30/50

JUL 29 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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed.....  
Student Embalmer

Signed *Lawrence* .....

Licensed Embalmer No. 2983

P. O. Address *Belmont Dis*

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.