

No. 300
10.48

FILED SEP 1 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29018

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 2006

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) b. STATE Mo c. COUNTY St. Louis	
b. CITY OR TOWN Flordell Hills		c. CITY OR TOWN Flordell Hills 4000	
d. FULL NAME OF HOSPITAL OR INSTITUTION 7141 Seymour Drive		d. STREET ADDRESS (if rural, give location) 7141 Seymour Drive	

3. NAME OF DECEASED (Type or Print) Elizabeth Hofmann			4. DATE OF DEATH (Month) (Day) (Year) Aug. 19, 1950		
a. (First)	b. (Middle)		c. (Last)		
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 10, 1892		9. AGE (In years last birthday) 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework & Clerk		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Chicago, Ill		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Nicklaus Strubhart		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE William Hofmann	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 497-07-1692		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Wm. Hoffmann 7141 Seymour Dr.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
<p>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Lymphatic Leukemia			4 mos
		ANTECEDENT CAUSES			
		MORBID CONDITIONS, if any, giving rise to the above cause (a) stating the underlying cause last.			
		DUE TO (b) _____			
		DUE TO (c) _____			
		II. OTHER SIGNIFICANT CONDITIONS			2040
		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) none		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 **5/1/50**, 19____, to **8/19/50**, 19____, that I last saw the deceased alive on **8/19/50**, 19____, and that death occurred at **2:40P** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) H. J. Stein MD		23b. ADDRESS 6917 W. Elmwood		23c. DATE SIGNED 8/21/50	
24a. BURIAL (Specify) Burial		24b. DATE 8/22/50		24c. NAME OF CEMETERY OR CREMATORY Friedens Cemetery	
DATE REC'D BY LOCAL REG. 8-22-50		REGISTRAR'S SIGNATURE Norbert R. Ormke MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Paschedag-Henke 2825 N. Grand Bld	

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

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 me

working under my personal supervision.

Student Embalmer No.

Signed [Signature]

Signed.....
Student Embalmer

Licensed Embalmer No. 4699

P. O. Address [Signature]

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.