

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28339**
7692

FILED SEP 13 1951

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BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY 0				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2169	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital				16. STREET ADDRESS (If rural, give location) 4518 Arsenal St. 0			
3. NAME OF DECEASED a. (First) ROSA (Type or Print)		b. (Middle) _____		c. (Last) Hoffmann		4. DATE OF DEATH (Month) (Day) (Year) 8 29 1951	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Feb. 7, 1867	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) St. Louis, Missouri 0		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Zach Sebold		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Sigmund			
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. ---		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Oliver A. Hoffmann-3640 Liermann			
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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis					INTERVAL BETWEEN ONSET AND DEATH 3 days	
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Cardiovascular disease					10 years unknown	
	DUE TO (c) Carcinoma of stomach c extensive metastases						
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 422.1H			
22. I hereby certify that I attended the deceased from June 1, 1948 , to Aug 29, 1951 , that I last saw the deceased alive on Aug 28, 1951 , and that death occurred at 7:25 A.M. , from the causes and on the date stated above.							
23a. SIGNATURE Lewis Liermann MD (Degree or title)				23b. ADDRESS 8231 Clayton Rd		23c. DATE SIGNED 8/29/51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9/1/51	24c. NAME OF CEMETERY OR CREMATORY SS Peter & Paul Cem.		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri		
DATE REC'D BY LOCAL REG. AUG 30 1951		REGISTRAR'S SIGNATURE J. Earl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Wacker-Heldrich		ADDRESS 3634 Gravois	

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed Robert Wheeler

Licensed Embalmer No. 2128

P. O. Address Atkins 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.