

FILED SEP 13 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 28450

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7905

1. PLACE OF DEATH a. COUNTY <u>1</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give town) <u>ST. LOUIS</u>	c. LENGTH OF STAY (in this place) _____	c. CITY (If outside corporate limits, write RURAL and give township) <u>ST. LOUIS 2239</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2641 ALLEN AV.</u>		e. STREET ADDRESS (If rural, give location) <u>2641 ALLEN AV. 0</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>LOUISE</u> b. (Middle) <u>LANIGAN</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>9-3-51</u>		
5. SEX <u>FEM.</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>FEB. 14 - 1871</u>		9. AGE (in years last birthday) <u>80 YRS.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NIL</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>OMo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>

13a. FATHER'S NAME <u>William Hoffmeister</u>	13b. MOTHER'S MAIDEN NAME <u>Mary BAUER</u>	14. NAME OF HUSBAND OR WIFE _____		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs M Hoffmeister 2641 Allen Av</u>		
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>myocarditis chronic</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arteriosclerosis + Hypertension</u> DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>  <u>several years</u>
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19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____ <u>443X</u>		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) _____
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? <u>fall</u>

22. I hereby certify that I attended the deceased from 8/14 1951, to 9/3/51, 1951, that I last saw the deceased alive on 8/29, 1951, and that death occurred at 9:15 p. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>W. Demko M.D.</u>	23b. ADDRESS <u>GRAVOIS 3430 Gravois Ave</u>	23c. DATE SIGNED <u>9/4/51</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>9-6-51</u>	24c. NAME OF CEMETERY OR CREMATORIUM <u>VALHALLA</u>	24d. LOCATION (City, town, or county) (State) <u>St Louis Co. Mo</u>
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DATE REC'D BY LOCAL REG. <u>SEP 5 1951</u>	REGISTRAR'S SIGNATURE <u>J. Earl Smith M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>E. J. Schuur 3125 Lafayette</u>
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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 *John B. Holman* \_\_\_\_\_

Licensed Embalmer No. *4014* \_\_\_\_\_

P. O. Address *3125 [unclear]* \_\_\_\_\_

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.