

V. S. No. 300
Rev. 10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29000

FILED AUG 23 1951

BIRTH NO. _____ REG. DIST. NO. 517 PRIMARY REG. DIST. NO. 3069 Registrar's No. 2877

1. PLACE OF DEATH a. COUNTY St. Louis 4005		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Richmond Heights	c. LENGTH OF STAY (In this place) 2 days	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis Maplewood 4534	d. STREET ADDRESS (If rural, give location) 7223 Gayola Avenue
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Hospital		d. STREET ADDRESS (If rural, give location) 7223 Gayola Avenue	

3. NAME OF DECEASED (Type or Print) Hugo T. Bofinger			4. DATE OF DEATH (Month) (Day) (Year) August 8, 1951		
a. (First)	b. (Middle) T.	c. (Last) Bofinger			

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 17, 1884	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
-------------	------------------------	----------------------------------------------------------------	--------------------------------	------------------------------------	------------------------	----------------------	-----------------------	----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President	10b. KIND OF BUSINESS OR INDUSTRY Manchester Iron Works	11. BIRTHPLACE (State or foreign country) Stuttgart, Germany	12. CITIZEN OF WHAT COUNTRY? U.S.A.
-------------------------------------------------------------------------------------------------------	---------------------------------------------------------	--------------------------------------------------------------	-------------------------------------

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE Christine Wolf
--------------------	---------------------------	--------------------------------------------

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. 493-05-5210	17. INFORMANT'S SIGNATURE OR NAME Mrs. Christine Bofinger, 7223 Gayola	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) Carcinoma of pancreas Antecedent causes: Metastases to liver Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 157X		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. SIGNATURE OF PHYSICIAN	

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 [] NOT WHILE AT WORK []	21f. HOW DID INJURY OCCUR?
-------------------------------------------------	--------------------------------------------------------------	----------------------------

22. I hereby certify that I attended the deceased from 6/9, 1951, to 8/8, 1951, that I last saw the deceased alive on 8/8, 1951, and that death occurred at 6:30P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Thomas E. Pondrace, M.D.	23b. ADDRESS 4660 Maplewood Ave.	23c. DATE SIGNED 8/8/51
-----------------------------------------------------------	----------------------------------	-------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Aug. 11, 1951	24c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
--------------------------------------------------	-------------------------	------------------------------------------------------	-------------------------------------------------------------------

DATE REC'D BY LOCAL REG. 8-10-51	REGISTRAR'S SIGNATURE Herbert P. Donke, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave.	ADDRESS
----------------------------------	----------------------------------------------	------------------------------------------------------------------------------	---------

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

Dr. Thos. C. Birdsall,
4660 Maryland Ave.

RO 6074

2:00 - 4:00 P.M.

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

Delit J. Krepsin

Licensed Embalmer No.

3497

P. O. Address

1936 St. Louis

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.