

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39155

State File No. _____

FILED DEC 1 1957

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Registrar's No. 10488

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> b. CITY OR TOWN <u>St. Louis</u> c. LENGTH OF STAY (in this place) <u>9 weeks</u> d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Ms MILLAN HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>ILLINOIS</u> b. COUNTY <u>ST CLAIR</u> c. CITY OR TOWN <u>Belleville</u> <u>8120</u> d. STREET ADDRESS (If rural, give location) <u>9508 W. MAIN ST</u> <u>0</u>			
3. NAME OF DECEASED (Type or Print) <u>EDWARD T HOEFMAN</u> a. (First) <u>EDWARD</u> b. (Middle) <u>T</u> c. (Last) <u>HOEFMAN</u>			4. DATE OF DEATH <u>Nov 24 1957</u> (Month) (Day) (Year)		5. SEX <u>M.D</u> 6. COLOR OR RACE <u>W.</u>		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>MAY 17 1884</u>		9. AGE (In years last birthday) <u>67</u> 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) <u>RETIRED CONTRACTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING</u>		11. BIRTHPLACE (State or foreign country) <u>ALTON ILL.</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <u>EMIL HOEFMAN</u>		13b. MOTHER'S MAIDEN NAME <u>FRANCES SCHALLER</u>		14. NAME OF HUSBAND OR WIFE <u>KATHERINE HOEFMAN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Katherine Schaffner</u> ADDRESS <u>321 Bank St. 90554 Mark St.</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CACHEXIA</u> <u>ADVANCED TERMINAL ME</u> <u>TASTES</u> DUE TO (b) _____ DUE TO (c) <u>CARCINOMA of the LARYNX</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>MALNUTRITION</u>					INTERVAL BETWEEN ONSET AND 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? <u>161X</u>					
22. I hereby certify that I attended the deceased from <u>9-17</u> , 19 <u>57</u> , to <u>11-24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11-24</u> , 19 <u>57</u> , and that death occurred at <u>3:04</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Donald H. King</u> M.D.				23b. ADDRESS <u>Barnes Hospital</u>		23c. DATE SIGNED <u>11/24/57</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>Nov 27 1957</u>		24c. NAME OF CEMETERY OR CREMATORY <u>MT. CARMEL</u>		24d. LOCATION (City, town, or county) (State) <u>Belleville</u>	
DATE RECEIVED BY LICENSEE <u>Nov 26 1957</u>		REGISTRAR'S SIGNATURE <u>J. Earl Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Nell Walsh Barnes</u> ADDRESS <u>East St. Louis Illinois</u>			

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 _____

not embalmed

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Philip Ogden

Licensed Embalmer No. *7091*

P. O. Address *East W. Louis, Ill.*

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.