

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

15812

State File No. ....

FILED MAY 14 1953

318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 4010

1. PLACE OF DEATH a. COUNTY		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, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2019	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony's Hospital		d. STREET ADDRESS (If rural, give location) 8123 Ivory Ave., 0	
3. NAME OF DECEASED (Type or Print) a. (First) Frank E. Hoffmann b. (Middle) c. (Last)			4. DATE OF DEATH Apr. 15, 1953
5. SEX male 0	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Mar. 28, 1877
9. AGE (In years last birthday) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bottler	11. BIRTHPLACE (City and State or Foreign Country) Missouri 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY soda	12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME Jacob Hoffmann		13b. MOTHER'S MAIDEN NAME Eva Unk	14. NAME OF HUSBAND OR WIFE Evelyn
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no no		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Evelyn Hoffmann 8123 Ivory
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, exsanguis, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute cardiac decompensation  ANTECEDENT CAUSES DUE TO (b) Prostatectomy; post-operative bladder hemorrhage DUE TO (c) Arterio-sclerosis  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION 3/25/53		19b. MAJOR FINDINGS OF OPERATION Hypertrophied prostate	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.  1 wk 2 yrs.	
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 (Month) (Day) (Year) (Hour) OF INJURY	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 61DX	
22. I hereby certify that I attended the deceased from 3/20, 1953, to Apr. 15, 1953, that I last saw the deceased alive on 4/15, 1953, and that death occurred at 1145p m., from the causes and on the date stated above.			
23a. SIGNATURE E. W. Smith M.D.		23b. ADDRESS 4145 a S. Grand Blvd.	
23c. DATE SIGNED 4/17/53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 4-18-58	
24c. NAME OF CEMETERY OR CREMATORY Barklawn Cem.		24d. LOCATION (City, town, or county) (State) Lemay 23, Mo.	
DATE REC'D BY LOCAL REG. APR 17 1953		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS SOUTHERN FUNERAL HOME 6822 S. GRAND BLVD. ST. LOUIS 11, MO.	

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

Dr. Peters

4145a S. Grand

11 to 1 p.m. Lo.7733

3 to 4

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 .....  
Student Embalmer

Student Embalmer No. \_\_\_\_\_

Signed

*Louise Ann Forson*

Licensed Embalmer No. *4242*

P. O. Address *6322 So. Grand*

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.