No. 300
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19492

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5173

0

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

1. PLACE OF DEATH
a. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis, Missouri
c. LENGTH OF STAY (in this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Louis City Hospital 2239

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis

d. STREET ADDRESS (If rural, give location): 2233 Indiana Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): CHARLES
b. (Middle): 0
c. (Last): HOFFMAN

4. DATE OF DEATH (Month) (Day) (Year): MAY 21, 1953

5. SEX: Male 0
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single 0
8. DATE OF BIRTH: Jan. 16, 1875
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months 4, Days 5 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Marble Worker
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country): St. Louis Mo. 0
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME: Frederick Hoffman
13b. MOTHER'S MAIDEN NAME: Mary Schirmer
14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Gerturde Smyth 4042a Folsom

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 4200

22. *I hereby certify that I attended the deceased from* 5-19-53, *19*___, *to* 5-21-53, *19*___, *that I last saw the deceased alive on* 5-21-53, *19*___, *and that death occurred at* 2:55P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): A M Huggins, MD 0
23b. ADDRESS: 1515 Lafayette Avenue
23c. DATE SIGNED: 5-22-53

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 5/23/53
24c. NAME OF CEMETERY OR CREMATORY: Concordia Cemetery
24d. LOCATION (City, town, or county) (State): St. Louis Mo.

DATE REC'D BY LOCAL REG.: MAY 22 1953
REGISTRAR'S SIGNATURE: J Carl Smith MD MSB
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: J.H. Gebhen Sons 2630 Gravois

(Licensed Embalmer's Statement on Reverse Side)

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 F. Gebben

Licensed Embalmer No. 4144

P. O. Address 2630 Gravois

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.