

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

22892

FILED JUL 2 - 1953

318

State File No. ....

5874

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE _____ Mo. b. COUNTY _____			
b. CITY OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>5815 Mardel Ave.</u>				e. STREET ADDRESS (If rural, give location) <u>14 5815 Mardel Ave. 2149</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>MARY</u>		b. (Middle) <u>MARGARET</u>		c. (Last) <u>HOFFMANN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 9 1953</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>Sep. 25, 1887</u>	
9. AGE (In years last birthday) <u>65</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? _____		13a. FATHER'S NAME <u>Albert Mueller</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Late Valentine Hoffmann</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Albert J. Hoffmann</u> ADDRESS <u>5815 Mardel Ave.</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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive Heart Disease</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 days</u>  <u>3 1/2 +</u>	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>No</u>		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>443X</u>			
22. I hereby certify that I attended the deceased from <u>December, 1949</u> , to <u>June 9, 1953</u> , that I last saw the deceased alive on <u>June 9, 1953</u> , and that death occurred at <u>4:05 P. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) of <u>Bernard T. Koon MD</u>				23b. ADDRESS <u>415 Morganfield Loop St. Louis 16, Mo.</u>		23c. DATE SIGNED <u>6/12/53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Jun. 13, 1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>	
DATE REC'D BY LOCAL REG. <u>JUN 12 1953</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Kriegshauser 4228 S. Kingshighway Bl.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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.....  
Signature of Student Embalmer

Signed *Del. J. J. Johnson*.....

Licensed Embalmer No. *453*  
P. O. Address *Louis N*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.