

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40607

FILED NOV 27 1953

State File No. 10810

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

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST LOUIS</u>		c. LENGTH OF STAY (In this place) <u>38 DAYS</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>MO BAPTIST HOSPITAL</u>		c. CITY OR TOWN <u>ARNOLD</u>	
		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
		e. STREET ADDRESS (If rural, give location) <u>RURAL-ROUTE-BOX 308</u>	

3. NAME OF DECEASED (Type or Print) <u>HANNAH FRIESEN HOFFEMAN</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>NOV-13-1953</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED 2</u>	8. DATE OF BIRTH <u>MAY-20-1869</u>		9. AGE (In years last birthday) <u>84</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) <u>SARATOFF RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>GEORGE BURGDORF</u>	13b. MOTHER'S MAIDEN NAME <u>MARGARET REICKERT</u>	14. NAME OF HUSBAND OR WIFE <u>JACOB FRIESEN</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>ALMA RATH-WEBSTER</u>	ADDRESS <u>GROVES-MO</u>
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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, asphemia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION: I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>MYOCARDIAL INFARCTION</u>		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) <u>CORONARY SCLEROSIS</u>		
	DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>LOCALIZED PERITONITIS</u>		

19a. DATE OF OPERATION <u>10/17/53</u>	19b. MAJOR FINDINGS OF OPERATION <u>FECAL FISTULA (TRANSVERSE COLON), VENTRAL HERNIA</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>4201</u>

22. I hereby certify that I attended the deceased from 10/10/53, to 11/12/53, that I last saw the deceased alive on 11/11/53, and that death occurred at 3:45 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Victor B Kieffer M.D.</u>	23b. ADDRESS <u>4500 OLIVE ST., ST. LOUIS</u>	23c. DATE SIGNED <u>11/14/53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>NOV-18-1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>OAK GROVE</u>	24d. LOCATION (City, town, or county) (State) <u>ST LOUIS-CO-MO</u>
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DATE REC'D BY LOCAL REG. <u>NOV 14 1953</u>	REGISTRAR'S SIGNATURE <u>J. Earl Smith</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Parker</u>	ADDRESS <u>Albion, Mo</u>
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EMC (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADEING 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 *Leslie Welch*.....

Licensed Embalmer No. *43*

P. O. Address *Walter St.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.