

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

**1823**

State File No. ....

BIRTH NO. FILED FEB 15 1954 REG. DIST. NO. 164 PRIMARY REG. DIST. NO. 3032 Registrar's No. 10

1. PLACE OF DEATH a. COUNTY <b>Johnson Johnson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b>		b. COUNTY <b>Pettis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Warrensburg,</b>		c. LENGTH OF STAY (in this place) <b>4 yrs.</b>		c. CITY OR TOWN <b>Sedalia,</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Nace's Nursing Home, IOE, Market</b>		e. STREET ADDRESS (If rural, give location) <b>901 S. Missouri</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or Print) <b>MARGARET</b>			a. (First)			b. (Middle)			c. (Last) <b>HOFFMAN</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Feb. 3rd, 1954</b>		
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5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>		8. DATE OF BIRTH <b>Oct. 29, 1893</b>		9. AGE (In years last birthday) <b>60</b>		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (City and State or Foreign Country) <b>Sedalia, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Invalid</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Invalid</b>											

13a. FATHER'S NAME <b>Louis Hoffman</b>			13b. MOTHER'S MAIDEN NAME <b>Ella Dimmitt</b>			14. NAME OF HUSBAND OR WIFE <b>Single</b>		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mr. Dimmitt Hoffman, Sedalia, Missouri</b>				ADDRESS <b>Sedalia, Missouri</b>	
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>① Coronary Occlusion</b>						INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES DUE TO (b) <b>✓</b> <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>							
		DUE TO (c) <b>✓</b>							
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>① Diabetes ② Epilepsy</b>							

19a. DATE OF OPERATION <b>1954</b>		19b. MAJOR FINDINGS OF OPERATION <b>4201</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>✓</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Warrensburg, Johnson mo</b>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Warrensburg, Johnson mo</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <b>✓</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>✓</b>	

22. I hereby certify that I attended the deceased from **June 1, 1952**, to **2-3**, 19**54**, that I last saw the deceased alive on **Feb 3**, 19**54**, and that death occurred at **10 A.M.** m., from the causes and on the date stated above.

23a. SIGNATURE <b>G. W. Gray</b>		(Degree or title) <b>M.D.</b>		23b. ADDRESS <b>Knobnoster, Missouri</b>		23c. DATE SIGNED <b>2-4-1954</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Feb. 5th, 1954</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Crown Hill Cemetery, Sedalia, Missouri</b>		24d. LOCATION (City, town, or county) (State) <b>Sedalia, Missouri</b>	
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DATE REC'D BY LOCAL REG. <b>Feb. 4, 1954</b>		REGISTRAR'S SIGNATURE <b>Savannah Crutcher</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Brauninger</b>		ADDRESS <b>Warrensburg, Mo.</b>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED  
APR 12 1955  
FEB 8 1954  
JOHNSON COUNTY HEALTH DEPT.

**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 *W. W. Saunders*.....

Licensed Embalmer No. *33*.....

P. O. Address *Warrens*.....

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.