

FILED MAR 15 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6327

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2110

| | | | | | | | |
|--|------------------------|--|---|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE Missouri b. COUNTY 2167 | | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS Mo | | c. LENGTH OF STAY (In this place) | | c. CITY OR TOWN 16 ST. LOUIS | | 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 INCARNATE WORD Hosp. | | | e. STREET ADDRESS (If rural, give location) 3149 PESTALOZZI | | | | |
| 3. NAME OF DECEASED (Type or Print) PETER - HOFFMANN | | | 4. DATE OF DEATH (Month) (Day) (Year) MAR. 5 1954 | | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED | 8. DATE OF BIRTH DEC. 29 1881 | | 9. AGE (In years last birthday) 72 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER HELPER | | | 10b. KIND OF BUSINESS OR INDUSTRY CHAMBER MOTOR | | 11. BIRTHPLACE (City and State or Foreign Country) Missouri | | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13a. FATHER'S NAME CONRAD HOFFMANN | | 13b. MOTHER'S MAIDEN NAME CATHERINE JOHNER | | 14. NAME OF HUSBAND OR WIFE ELIZABETH HOFFMANN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT'S SIGNATURE OR NAME Elizabeth Hoffmann 3149 Pestalozzi | | | |
| 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, ashenia, etc. It means the disease, injury, or complication which caused death. | | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ACUTE CONGESTIVE HEART FAILURE ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) AURICULAR FIBRILLATION 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 10 days 1 yr | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 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? 4331 | | | |
| 22. I hereby certify that I attended the deceased from Mar 1, 1954 to Mar 5, 1954, that I last saw the deceased alive on Mar 5, 1954, and that death occurred at 8:45 p.m., from the causes and on the date stated above. | | | | | | | |
| 23. SIGNATURE Min T Vandover (Degree or title) 0 MD | | | 23b. ADDRESS 1504 So Grand | | | 23c. DATE SIGNED 3/6/54 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | | 24b. DATE MAR 8 1954 | | 24c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEM | | 24d. LOCATION (City, town, or county) (State) ST. LOUIS Mo | |
| DATE REC'D BY LOCAL REG. MAR 8 1954 | | REGISTRAR'S SIGNATURE J. Carl Smith MD | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thomas Kutis 2906 Beavon | | | |

(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 *Lawrence E. Hill*.....

Licensed Embalmer No. *434*
P. O. Address *2916*.....

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.