

FILED JAN 18 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43673
State File No. 11363
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	c. LENGTH OF STAY (In this place) 8 yrs.	c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION 1438 E. Grand		e. STREET ADDRESS (If rural, give location) 1438 E. Grand 2099	

3. NAME OF DECEASED (Type or Print)		a. (First) Louis	b. (Middle)	c. (Last) Hoffman	4. DATE OF DEATH (Month) (Day) (Year) Dec. 13, 1954	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed		8. DATE OF BIRTH Apr. 12, 1874	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR: MONTHS _____ DAYS _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Repairer		10b. KIND OF BUSINESS OR INDUSTRY Shoes		11. BIRTHPLACE (City and State or Foreign Country) Russia		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Unknown Hoffman		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME B. Wiffield ADDRESS 1438 E. Grand Ave.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobar Pneumonia		DUE TO (b) Arteriosclerosis Gen.			2 days
DUE TO (c) Hypertension					
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			many years

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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 490x	

22. I hereby certify that I attended the deceased from **Sept 1954** to **12/13, 1954** that I last saw the deceased alive on **12/12, 1954** and that death occurred at **1:15 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Ray Greenbaum MD		23b. ADDRESS 4652 Maryland		23c. DATE SIGNED 12/14/54	
24a. BURIAL CREMATION REMOVAL (Specify)		24b. DATE 12/14/1954		24c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth	
24d. LOCATION (City, town, or county) (State) University City, Mo.					

DATE REC'D BY LOCAL REG. DEC 14 1954		REGISTRAR'S SIGNATURE Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE Berge r Memorial ADDRESS 4715 McPherson Ave.	
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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..... *Paul D. Quilley*

Licensed Embalmer No. *4227*

P. O. Address

**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.**