

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **0741**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) Town St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospital		e. STREET ADDRESS (If rural, give location) 5443 Oriole Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) Wilbur b. (Middle) F. c. (Last) Hoffman		4. DATE OF DEATH (Month) (Day) (Year) Jan. 24, 1955	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept 14 1914
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector-City of St. Louis Sewers & Paving		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) Months Days 40 4 10
11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Edward Hoffman	13b. MOTHER'S MAIDEN NAME Nellie Francis	14. NAME OF HUSBAND OR WIFE Nancy Helen Hoffman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW#2	16. SOCIAL SECURITY NO. 494-10-7172	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs Nancy Hoffman 5443 Oriole St. Louis

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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Nephritis acute		4 mo
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Aneurysm left renal artery DUE TO (c) Hypertension, malignant		undetermined
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			4 mo.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 445X
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22. I hereby certify that I attended the deceased from **10.16**, 19**54**, to **1.24**, 19**55**, that I last saw the deceased alive on **1.23**, 19**55** and that death occurred at **7A** m., from the causes and on the date stated above.

23a. SIGNATURE Chas. J. ...	23b. ADDRESS 6000 W. Flourissant	23c. DATE SIGNED 1.25.55
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan. 27 1955	24c. NAME OF CEMETERY OR CREMATORY Clavary
24d. LOCATION (City, town, or county) (State) St. Louis Mo.		

DATE REC'D BY LOCAL REG. JAN 25 1955	REGISTRAR'S SIGNATURE Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE J. Donnelly	ADDRESS 3840 Lindell Blvd.
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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 me....., Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Wm. S. Ryan.....

Licensed Embalmer No. 467.....

P. O. Address 3840 Lenox.....

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.