

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6939

State File No.

FILED MAR 9 1955

BIRTH NO.		REG. DIST. NO. <u>322</u>		PRIMARY REG. DIST. NO. <u>6088</u>		Registrar's No. <u>916</u>			
1. PLACE OF DEATH a. COUNTY <u>Saline</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Saline</u>					
b. CITY (If outside corporate limits, write RURAL and give township) <u>Rural, Manning</u>		c. LENGTH OF STAY (In this place) <u>4 days</u>		c. CITY OR TOWN <u>Slater</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <u>0970</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>4 Miles West Slater</u>				f. STREET ADDRESS (If rural, give location) <u>320 North Central St</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Johannie Mae</u> b. (Middle) <u>Hoffmeyer</u> c. (Last) <u>Hoffmeyer</u>			4. DATE OF DEATH Month (Day) (Year) <u>Febry-24-55</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		
7. MARRIED - NEVER MARRIED - WIDOWED - DIVORCED - <u>WIDOWED</u>		8. DATE OF BIRTH <u>Febry 29 1896 = 58</u>		9. AGE (In years) if UNDER 1 YEAR if birthdate <u>29</u> Months <u>11</u> Days <u>2</u> Hours <u>5</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of work life, or if retired) <u>Manager of Shop</u>			
10b. KIND OF BUSINESS OR INDUSTRY <u>Carnet and Beer</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Vandalia Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>John Hall</u>			
13b. MOTHER'S MAIDEN NAME <u>Cora Sage</u>		14. NAME OF HUSBAND OR WIFE <u>Howard Hoffmeyer</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>193X</u>			
17. INFORMANT'S SIGNATURE OR NAME <u>Howard Hoffmeyer</u>		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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <u>Astrocytoma 2 frontal & parietal</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <u>Region of Brain</u> DUE TO (b) _____ 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	
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		22. I hereby certify that I attended the deceased from <u>Nov 16</u> , 19 <u>54</u> to <u>Feb 24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Feb 18</u> , 19 <u>55</u> , and that death occurred at <u>8:57</u> m., from the causes and on the date stated above.		23a. SIGNATURE <u>James A. Reed M.D.</u>		23b. ADDRESS <u>Marshall Mo</u>			
23c. DATE SIGNED <u>2-26-55</u>		24a. BURIAL, CREMATION, OR REMOVAL (Specify)		24b. DATE <u>2-27-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Slater City</u>			
24d. LOCATION (City, town, or county) (State) <u>Slater Mo</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Earl C. Metz</u>		25. ADDRESS <u>Slater Mo</u>		DATE REC'D BY LOCAL REG. <u>2-27-55</u>			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

MAR 26 1955

JUN 2 1955

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 *James E.*
Licensed Embalmer No.
P. O. Address *State*

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.