

FILED APR 28 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13461**
Registrar's No. **3248**

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

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

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 13461		Registrar's No. 3248			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Boone							
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis, Mo.			c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN Columbia		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL				e. STREET ADDRESS (If rural, give location) Hiway 40 East							
3. NAME OF DECEASED (Type or Print) a. (First) William			b. (Middle) W.			c. (Last) Hoffman			4. DATE OF DEATH (Month) (Day) (Year) April 9, 1955		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married		8. DATE OF BIRTH Apr 19, 1925		9. AGE (In years last birthday) 29		If UNDER 1 YEAR Months Days	If UNDER 2 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bakery				10b. KIND OF BUSINESS OR INDUSTRY Quality Bakery		11. BIRTHPLACE (City and State or Foreign Country) Columbia Mo			12. CITIZEN OF WHAT COUNTRY? U.S.A		
13a. FATHER'S NAME Wallace Hoffman			13b. MOTHER'S MAIDEN NAME Mabel Coats			14. NAME OF HUSBAND OR WIFE None					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Wallace Hoffman Columbia Mo							
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) Cranial Nerve (VIII) Tumor non-malignant						INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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.							
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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 223x							
22. I hereby certify that I attended the deceased from April 5, 1955 , to April 9, 1955 that I last saw the deceased alive on April 9, 1955 , and that death occurred at 4:50 AM from the causes and on the date stated above.											
23a. SIGNATURE E. J. McMillan M.D. (Degree or title)				23b. ADDRESS BARNES HOSPITAL				23c. DATE SIGNED 4/9/55			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 4-9-55		24c. NAME OF CEMETERY OR CREMATORY _____			24d. LOCATION (City, town, or county) (State) Columbia, Mo.				
DATE REC'D BY LOCAL REG. APR 11 1955		REGISTRAR'S SIGNATURE J. Carl Smith M.D.			25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe			ADDRESS 4700 Washington.			

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 *Edward H. Rembert*.....

Licensed Embalmer No. *428*.....

P. O. Address *St. Louis*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.