

FILED AUG 2 - 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 23869

5667

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1009</b>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town(ship)) OR TOWN <b>Saint Louis</b>		c. LENGTH OF STAY (In this place) town(ship) _____		c. CITY OR TOWN <b>Saint Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> <b>0</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>5326 Lindenwood Place</b>				e. STREET ADDRESS (If rural, give location) <b>14 5326 Lindenwood Place</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Nanon</b> b. (Middle) <b>Clendenin</b> c. (Last) <b>Hoffmann</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>6 29 1955</b>				
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>2-12-1898</b>	
9. AGE (In years last birthday) <b>57</b>		10. MONTHS <b>4</b>		11. DAYS <b>17</b>		12. HOURS <b>17</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Saint Louis, Missouri</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13a. FATHER'S NAME <b>Harry Fulks</b>			13b. MOTHER'S MAIDEN NAME <b>Maud Wurtz</b>			14. NAME OF HUSBAND OR WIFE <b>Reyburn Hoffmann</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Reyburn Hoffmann 5326 Lindenwood Pl</b>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute Myocardial Infarction</b> (b) <b>Coronary Artery Occlusion</b> (c) <b>Arteriosclerotic Heart Disease 2 Yrs</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>	
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 <b>4200</b>			
22. I hereby certify that I attended the deceased from <b>Nov 4<sup>th</sup></b> , 19 <b>55</b> to <b>June 29, 1955</b> , that I last saw the deceased alive on <b>6/3</b> , 19 <b>55</b> , and that death occurred at <b>8:45</b> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>David S. West MD</b>				23b. ADDRESS <b>4409 Tridenevood</b>		23c. DATE SIGNED <b>6/30/55</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		24b. DATE <b>7-2-1955</b>		24c. NAME OF CEMETERY OR CREMATORY/ <b>Valhalla Chapel of Memories</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo</b>	
DATE REC'D BY LOCAL REG. <b>JUN 30 1955</b>		REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>		FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>HOFFMEISTER COLONIAL MORTUARY 6464 Chippewa Street, St. Louis, Mo</b>			

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

(Licensed Embalmer's Statement on Reverse Side)

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..... *Harry J. Schenck*

Licensed Embalmer No. *2679*

P. O. Address *7874 Grand*

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.