

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

42185

State File No. _____

Registrar's No. **11125**

FILED JAN 6 - 1956

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. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) 63 yrs.		d. 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 Deaconess Hospital		e. STREET ADDRESS (If rural, give location) 5450 Genevieve Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) SOPHIA b. (Middle) W. c. (Last) HOFMANN			4. DATE OF DEATH (Month) (Day) (Year) Dec. 19, 1955.		
---	--	--	--	--	--

5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH March 1, 1874		9. AGE (In years) (last birthday) 81		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 14 HRS. Hours _____ Min. _____	
-----------------------------	--	--------------------------------------	--	--	--	--	--	--	--	--	--	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (City and State or Foreign Country) Clinton County, Illinois.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
---	--	--	--	--	--	--	--	--	---	--	--

13a. FATHER'S NAME Unknown Faber			13b. MOTHER'S MAIDEN NAME Anna Doepke			14. NAME OF HUSBAND OR WIFE Henry Hofmann		
--	--	--	---	--	--	---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME Miss Hazel Hofmann, 5450 Genevieve Ave.		ADDRESS _____	
---	--	---	--	---	--	----------------------	--

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, asphyxia, 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) Metastatic Carcinoma of Lungs						17r	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of breast						2 yrs	
		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 170x						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? _____	
--	--	--	--	---	--

22. I hereby certify that I attended the deceased from April 24, 1954, to Dec. 7, 1955, that I last saw the deceased alive on Dec. 18, 1955, and that death occurred at 3:20 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Bob N Klein M.D.) (Degree or title) _____		23b. ADDRESS 7637 S. Kingshighway		23c. DATE SIGNED 12-20-55	
---	--	---	--	---	--

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 12/22/55.		24c. NAME OF CEMETERY OR CREMATORY New Bethlehem Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.	
---	--	-----------------------------------	--	---	--	---	--

DATE REC'D BY LOCAL REG. DEC 20 1955		REGISTRAR'S SIGNATURE Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Calvin F. Feutz, 4828 Natural Bridge Blvd.		ADDRESS _____	
--	--	---	--	---	--	----------------------	--

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-48

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 *Ralph C. Zindler*.....

Licensed Embalmer No. *42*.....

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

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.