

FILED FEB 6 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1727

BIRTH NO. _____ REG. DIST. NO. 159 PRIMARY REG. DIST. NO. 5590 Registrar's No. 5

1. PLACE OF DEATH a. COUNTY JEFFERSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY City	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL BIG RIVER		c. CITY OR TOWN ST LOUIS	
c. LENGTH OF STAY (in this place) 1-DAY		d. Is 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 GRUBVILLE Mo			
No. STREET ADDRESS 5622 MILENTZ		(If rural, give location) 2021	

3. NAME OF DECEASED (Type or Print) a. (First) IRVING b. (Middle) WILLIAM c. (Last) HOFFMEISTER		4. DATE OF DEATH (Month) (Day) (Year) JAN 15 - 1956	
5. SEX M	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JULY 11 - 1918
9. AGE (In years last birthday) 37		10. UNDER 1 YEAR Months 7	11. UNDER 2 HRS. Days 11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BANKER		10b. KIND OF BUSINESS OR INDUSTRY HE MAY BANK	11. BIRTHPLACE (City and State or Foreign Country) HOUSE SPRINGS Mo
13a. FATHER'S NAME HENRY HOFFMEISTER		13b. MOTHER'S MAIDEN NAME CLARA NOLLMAN	14. NAME OF HUSBAND OR WIFE FASIE (VOGEL) HOFFMEISTER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. YES H.W.N.-2 308-09-7705	17. INFORMANT'S SIGNATURE OR NAME Elsie Hoffmeister
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.		18. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Arteriosclerosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Natural Causes 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 4201	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. YES H.W.N.-2 308-09-7705		17. INFORMANT'S SIGNATURE OR NAME Elsie Hoffmeister		ADDRESS 5622 MILENTZ	
--	--	--	--	---	--	--------------------------------	--

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.		18. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Arteriosclerosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Natural Causes 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 4201		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE D. B. Edwards		(Degree or title)		23b. ADDRESS Cedar Hill Mo		23c. DATE SIGNED 1/16/56	
24a. BURIAL, CREMATION, OR REMOVAL (Specify) burial		24b. DATE 1/18/56		24c. NAME OF CEMETERY OR CREMATORY St Hope Cem		24d. LOCATION (City, town, or county) (State) St Louis Mo	

DATE REC'D BY LOCAL REG. 1-24-56		REGISTRAR'S SIGNATURE Kathleen		FEDERAL DIRECTOR'S SIGNATURE Gigenheim		ADDRESS Brooklyn Missouri	
--	--	--	--	--	--	-------------------------------------	--

(Licensed Embalmer's Statement on Reverse Side)

St Louis - Mo

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

JEFFERSON COUNTY HEALTH DEPT.
HILLSBORO, MISSOURI

DATE RECEIVED

JAN 30 1958

FEB 6 1958

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.....
Jan M. Simon

Licensed Embalmer No. *431*

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.