No. 300
10.48

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

FILED MAR 5 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6647

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1280

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 6335 Marquette

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY:
c. CITY OR TOWN: St. Louis
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐
e. STREET ADDRESS (If rural, give location): 6335 Marquette

3. NAME OF DECEASED (Type or Print)
a. (First): AUBIE
b. (Middle): M
c. (Last): HOFFMAN

4. DATE OF DEATH (Month) (Day) (Year): 2-5-1956

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 6-30-1911
9. AGE (In years last birthday): 44 — IF UNDER 1 YEAR: Months 7 Days 5 — IF UNDER 24 HRS.: Hours Min.

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

13a. FATHER'S NAME: John I Kowolskey
13b. MOTHER'S MAIDEN NAME: Mary R Rypel
14. NAME OF HUSBAND OR WIFE: Deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Leona Murphy 6337 Marquette

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* (a) Cerebral Apoplexy — INTERVAL BETWEEN ONSET AND DEATH

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: 334 x
20. AUTOPSY? YES ☑ NO ☐

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) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 10:00 AM, from the causes and on the date stated above.*

23a. SIGNATURE (Title or title): James M Kelly Deputy Coroner
23b. ADDRESS: 1300 Clark
23c. DATE SIGNED: 2-6-56

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 2-8-1956
24c. NAME OF CEMETERY OR CREMATORY: S.S. Peter & Paul CEm
24d. LOCATION (City, town, or county) (State): St. Louis Mo

DATE REC'D BY LOCAL REG.: FEB 6 1956
REGISTRAR'S SIGNATURE: J Carl Smith MD
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: WINGBERMUEHLE 3819 So. Grand Blvd

(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 embal

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed George J. Amphermaehl

Licensed Embalmer No. 4611

P. O. Address Room 18 M

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