

FILED APR 15 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **7594**

BIRTH NO. _____		REG. DIST. NO. <b>38</b>		PRIMARY REG. DIST. NO. <b>3006</b>		Registrar's No. <b>122</b>	
1. PLACE OF DEATH a. COUNTY <b>Boone</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Calloway</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Columbia</b>		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <b>Auxvasse</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>0140</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Betty</b>			b. (Middle) <b>Jo</b>		c. (Last) <b>Hoffman</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Apr. 10 - 57</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Aug 19 1927</b>		9. AGE (In years last birthday) <b>29</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>Columbia Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Joe Muster</b>			13b. MOTHER'S MAIDEN NAME <b>Lois Wynn</b>		14. NAME OF HUSBAND OR WIFE <b>Virgil Hoffman</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____			16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <b>Virgil Hoffman Auxvasse Mo</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of Cervix</b>		ANTECEDENT CAUSES					18 mo.
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) <b>Unknown</b>					
		DUE TO (c)					
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death. <b>171X</b>					
19a. DATE OF OPERATION <b>Jan 31, 1957</b>		19b. MAJOR FINDINGS OF OPERATION <b>Far advanced carcinoma of cervix</b>				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> 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) (Min.)		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 <b>Jan 18</b> , 1957, to <b>April 10</b> , 1957, that I last saw the deceased alive on <b>April 10</b> , 1957, and that death occurred at <b>9:00</b> p.m., from the causes and on the date stated above.							
23a. SIGNATURE <b>J. S. Roden M. D.</b> (Degree or title)				23b. ADDRESS <b>Wentz &amp; Co. Inc. Calloway</b>		23c. DATE SIGNED <b>4/10/57</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>4-12-57</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Anderson Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Auxvasse Mo.</b>		
DATE REC'D BY LOCAL REG. <b>Apr. 11 1957</b>		REGISTRAR'S SIGNATURE <b>Mrs. R. E. Palmer</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Marjorie Funeral Home</b> ADDRESS <b>Calloway Mo.</b>			

(Licensed Embalmer's Statement on Reverse Side)

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

APR 3 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 *J. J. Rossor*

Licensed Embalmer No. *2555*

P. O. Address *Pullman*

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.