

FILED JUL 26 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **26201**  
Registrar's No. **5959**

BIRTH NO.		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>5959</b>	
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 township) <b>St. Louis</b>		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <b>St. Louis</b>		d. In Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) <b>38 HOSPITAL OR INSTITUTION En Route to City Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>8101 Parkridge Drive</b>			
3. NAME OF DECEASED a. (First) <b>FRANK</b> (Type or Print)			b. (Middle) <b>Jr.</b>		c. (Last) <b>HOFFMAN</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>6-25-1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>9-17-1882</b>		9. AGE (In years, last birthday) <b>74</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 18 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>James Chevrolet</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Frederick Hoffman</b>			13b. MOTHER'S MAIDEN NAME <b>Fredericka Kaiser</b>		14. NAME OF HUSBAND OR WIFE <b>Katherine Hoffman</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>489-05-8249</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <i>Katherine Hoffman</i> <b>8101 Parkridge Drive</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carbon monoxide</b>				INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES As for conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>poisoning suffered in garage of home June 25, 1957</b> DUE TO (c) <b>Suicide</b>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>9733</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>Suicide</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>See above</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>June 25, 57 m.</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>See above</b>			
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 <b>8:30 A. m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <i>James M. Kelly</i>				23b. ADDRESS <b>1300 Clark</b>		23c. DATE SIGNED <b>6-26-57</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>6-28-1957</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>7600 St. Charles Rock Road MO</b>		
DATE REC'D BY LOCAL HEALTH OFFICER <b>JUN 26 57</b>		REGISTRAR'S SIGNATURE <i>Carl Smith</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>W. B. Regenstein</i>		ADDRESS <b>6409 Gravois Ave.</b>	

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

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STATE OF MISSOURI

DEPARTMENT OF HEALTH

1918-1919

STATEMENT

FORM

BY

STATE-11-1

REGISTERED

EMBALMER

NAME

DATE

REGISTERED

EMBALMER

NAME

REGISTERED

EMBALMER

REGISTERED

STATE OF MISSOURI

DEPARTMENT OF HEALTH

FORM

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 *Van M. Szymanski*

Licensed Embalmer No. *434*

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.

On this body is not embalmed, fact should be so stated above.