

Health, Welfare, Public Service  
 300-1-56  
 All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

FILED JUL 17 1957

26959

STATE FILE NUMBER

Registration District No. 312 Primary Registration District No. 590 Registrar's No. 1592

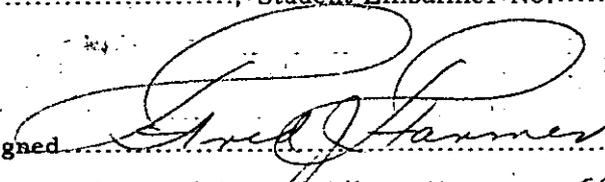
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Glendale</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Glendale</u> <u>4651</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1020 Nolan Drive</u>		Length of stay in lb <u>years</u>	d. STREET ADDRESS (If outside, give location) <u>1020 Nolan Drive</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MELVIN</u> Middle <u></u> Last <u>HOFFMAN</u>			4. DATE OF DEATH Month <u>June</u> Day <u>21</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 17, 1871</u>	9. AGE (In years last birthday) <u>86</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Co-Founder</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Hoffman, Marquard Machinery Co.</u>	11. BIRTHPLACE (City and state or country) <u>Irwin, Penna.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>John B. Hoffman</u>			14. MOTHER'S MAIDEN NAME <u>Francis Zeiser</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>492-24-9547</u>	17. INFORMANT Address <u>Philip M. Hoffman, #7 Lynnbrook Clayton</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>apoplexy</u> <u>diabetes</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u></u> DUE TO (c) <u></u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerosis</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>		
20c. TIME OF INJURY Hour <u></u> Month <u></u> Day <u></u> Year <u></u> a. m. <u></u> p. m. <u></u>		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>none</u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE	
21. I attended the deceased from <u>4/3/43</u> to <u>June 21, 1957</u> and last saw <u>him</u> alive on <u>June 2/ '57</u> Death occurred at <u>June 20</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Burton C. Hall</u> M. D.		22b. ADDRESS <u>3902 Lafayette</u>		22c. DATE SIGNED <u>June 21, '57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>June 24, '57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New St. Marcus Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Ambruster Mortuary, 6633 Clayton Rd.</u>		25. DATE RECD. BY LOCAL REG. <u>6-24-57</u>	26. REGISTRAR'S SIGNATURE <u>Herbert A. Dumble</u>		

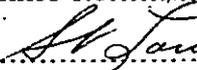
(Licensed Embalmer's Statement on Reverse Side)

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ..... Student Embalmer No. ....  
working under my personal supervision..

Student .....  
Signature of Student Embalmer

Signed  .....  
Licensed Embalmer No. ....

P. O. Address  .....

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