

Health,  
Welfare  
Public  
Service

28263

FILED AUG 30 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1007 Registrar's No. 3717

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|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>JACKSON</u>  |  | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>KANSAS CITY</u>                  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN <u>KANSAS CITY</u><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>ST JOSEPH HOSPITAL</u> |  | Length of stay in lb <u>37 YRS.</u>  | d. STREET ADDRESS <u>5116 LYDIA AVE</u> (If outside, give location)<br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

|   |                                  |   |  |  |   |
|---|----------------------------------|---|--|--|---|
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>SARAH ELIZABETH HOFFMAN</u>                      |                                  |   | 4. DATE OF DEATH<br>Month Day Year<br><u>AUG. - 6 - 1957</u>           |  |   |
| 5. SEX<br><u>FEMALE</u>   | 6. COLOR OR RACE<br><u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><u>MARRIED</u> | 8. DATE OF BIRTH<br><u>JULY 25 - 1898</u>                              | 9. AGE (In years)<br><u>59</u> (In days) | IF UNDER 1 YEAR<br>Months Days Hours Min.       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>---</u>   | 11. BIRTHPLACE (City and state or country)<br><u>MOBERLY, MISSOURI</u> |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u> |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 13a. FATHER'S NAME<br><u>OSCAR E. SHEDD</u>   |  | 13b. MOTHER'S MAIDEN NAME<br><u>AMAND J. ARCHER</u> |  | 14. NAME OF HUSBAND OR WIFE<br><u>OSCAR R. HOFFMAN</u> |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u> |  | 16. SOCIAL SECURITY NO.<br><u>NONE</u>              | 17. INFORMANT<br>Address<br><u>OSCAR R. HOFFMAN 5116 LYDIA AVENUE KANSAS CITY, Mo.</u> |  |  |

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|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 wks.</u>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   | DUE TO (b) <u>Arteriosclerotic Heart Disease</u> |   |
|  | DUE TO (c) <u>4200</u>                           |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)                                |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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|--|--|--|--|---|--|
| 20a. ACCIDENT SUICIDE HOMICIDE<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |   |  |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. p.m.  |  |  |  |   |  |
| 20d. INJURY OCCURRED WHILE AT <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 July 27, 1957 to Aug. 6, 1957 and last saw him alive on Aug. 6, 1957  
Death occurred at 12:55 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE<br><u>Martin P. Hunter M.D.</u> (Degree or title) | 22b. ADDRESS<br><u>1408 W. Waltham Bldg</u> | 22c. DATE SIGNED<br><u>Aug 6, 1957</u> |
|--|---|--|

|  |                                   |  |  |
|--|-----------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u> | 23b. DATE<br><u>AUG. 8 - 1957</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>MT. MORIAH CEMETERY</u> | 23d. LOCATION (City, town, or county) (State)<br><u>KANSAS CITY MISSOURI</u> |
|--|-----------------------------------|--|--|

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|---|---|---|
| 24. FUNERAL DIRECTOR<br><u>D. W. NEWCOMER'S SONS</u> ADDRESS<br><u>3318 USH CREEK P.C., MO.</u> | 25. DATE RECD. BY LOCAL REG.<br><u>8-8-57</u> | 26. REGISTRAR'S SIGNATURE<br><u>Reva Minshall</u> |
|---|---|---|

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Martin P. Hunter

All diseases in Part I must be causally related.



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 *Adrian Jay Stitt*

Licensed Embalmer No. *4882*  
P. O. Address *K.C., Mo.*

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.