

FILED FEB 17 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-008222
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 271

| | | | | | |
|---|-------------------------------|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u> | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Heights</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Clayton</u> <u>44520</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>St. Mary's Hospital</u> | | Length of stay in lb <u>1-mon.</u> | d. STREET ADDRESS (If outside, give location) <u>7546 Byron Place</u> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Jeanette</u> Middle <u>Hoffman</u> Last <u>Hoffman</u> | | | 4. DATE OF DEATH Month <u>Jan.</u> Day <u>29</u> Year <u>1958</u> | | |
| 5. SEX <u>F.</u> | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 2, 1895</u> | | 9. AGE (In years last birthday) <u>62</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during past 12 months, if retired) <u>Housewife-at home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u> | 11. BIRTHPLACE (City and state or country) <u>Phil. Pa.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> |
| 13a. FATHER'S NAME <u>Jerome Swanger</u> | | 13b. MOTHER'S MAIDEN NAME <u>Elizabeth Fox</u> | | 14. NAME OF HUSBAND OR WIFE <u>Mr. George Hoffman</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>none</u> | 17. INFORMANT Address <u>Mr. George Hoffman, 7546 Byron Place, 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>Non specific lymphoma with distant cell metastases.</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | <u>2002</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? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 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.) | | |
| 20c. TIME OF INJURY Hour _____ Month, Day, Year _____ 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 <u>11/19/56</u> to <u>1/29/58</u> and last saw her ^{her} _{him} alive on <u>1/28/58</u> Death occurred at <u>5:00 am.</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Thomas Parker M.D.</u> | | | 22b. ADDRESS <u>St. Louis Mo 4660 Maryland</u> | | 22c. DATE SIGNED <u>1/24/58</u> |
| 23a. BURIAL, CREMATION, REBURYAL (Specify) | | 23b. DATE <u>Jan. 29, 1958</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Crematory</u> | |
| | | | | 23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri.</u> | |
| 24. FUNERAL DIRECTOR <u>Arthur J. Donnelly</u> | | ADDRESS <u>3840 Lindell Blvd.</u> | | 25. DATE RECD. BY LOCAL REG. <u>Jan 29 1958</u> | |
| 26. REGISTRAR'S SIGNATURE <u>Kerber R Donke MD</u> | | | | | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Death, coroner, etc., must be causally related. All diseases in Part I must be causally related.

acc

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

(not embalmed)

Student
Signature of Student Embalmer

Signed *[Signature]*

Licensed Embalmer No. *4699*

P. O. Address *3840 Landry*

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.