

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023392
STATE FILE NUMBER

FILED JUN 27 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5863

5. 300
1-57
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Saint Louis		c. CITY OR TOWN Marine	
3. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hosp.		4. STREET ADDRESS (If outside, give location) No Address	
5. NAME OF DECEASED (Type or print) First Middle Last MARGARET TAYLOR HOFFMAN		6. DATE OF DEATH Month Day Year June 5, 1958	
7. SEX Female	8. COLOR OR RACE White	9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	10. DATE OF BIRTH Oct. 31, 1911
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		12. KIND OF BUSINESS OR INDUSTRY Ford Agency	13. BIRTHPLACE (City and state or country) Minnesota / U. S. A.
14. FATHER'S NAME James Cameron		15. MOTHER'S MAIDEN NAME Helen Taylor	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 17. INFORMANT Address 351-22-5466 Raymond Hoffman -Marine, Illinois	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Status post craniotomy - Ca of head of			
DUE TO (c) Pancreas & metastasis to liver, spinal cord & kidneys			
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.) 157x	
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 March 15, 1958 to June 5th 1958 and last saw ^{her} / _{him} alive on June 4th 1958 Death occurred at 6:30A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Dr. Tubere Leganna - M.D.		22b. ADDRESS St. Luke's Hospital	
22c. DATE SIGNED 6-6-58			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6-7-58	23c. NAME OF CEMETERY OR CREMATORY Marine Cemetery	23d. LOCATION (City, town, or county) (State) Marine, Illinois
24. FUNERAL DIRECTOR E. St. Louis, Ill.		25. DATE RECD. BY LOCAL REG. JUN 6 '58	26. REGISTRAR'S SIGNATURE Carl Smith

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 Not Embalmed, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed Joseph J. [Signature]
Licensed Embalmer No. 7541

P. O. Address East St. [Signature]

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.