

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-030529  
STATE FILE NUMBER

FILED SEP 15 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

7972

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>Clayton</b> <i>44520</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. Baptist Hosp</b>		d. STREET ADDRESS (If outside, give location) <b>7531 Forsythe</b>	
3. NAME OF DECEASED (Type or print) First <b>Mathilda</b> Middle <b>Hoffmann</b> Last <b>Hoffmann</b>		4. DATE OF DEATH Month <b>Aug</b> Day <b>14</b> Year <b>1958</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar 12 1876</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis Co., Mo. 0</b>
13a. FATHER'S NAME <b>Geo. Bauer</b>		13b. MOTHER'S MAIDEN NAME <b>Anna Preiss</b>	14. NAME OF HUSBAND OR WIFE <b>Wm. Hoffmann</b>
15. WAS DECEASED MEMBER 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>no</b>	17. INFORMANT <b>Otto Bauer 7531 Forsythe Clayton Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>mesenteric thrombosis</b> DUE TO (b) <b>Hypertensive and arterio-sclerotic cardio-vas-cular disease</b> DUE TO (c) <b>renal disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
19a. 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.) <b>443x</b>
20c. TIME OF INJURY Hour <b>5</b> Month, Day, Year			
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 <b>Aug 14 1958</b> to <b>Aug 14 1958</b> and last saw her alive on <b>Aug 14 1958</b> Death occurred at <b>3:45</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Richard Jones M.D.</b>		22b. ADDRESS <b>3720 Washington</b>	22c. DATE SIGNED <b>8-15-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8-16-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Manchester Mo.</b>
24. FUNERAL DIRECTOR <b>Schrader Funeral Home Ballwin Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>AUG 16 '58</b>	26. REGISTRAR'S SIGNATURE <b>J. Earl Smith - M.D.</b>

USE ONLY BLACK INK OR RUBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MS  
APR 26 1980

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 Richard Bopp  
Licensed Embalmer No. 4584

P. O. Address Bellvue, N.C.

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.