Health,
& Welfare
Public
Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED OCT 10 1958

58-034336
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9468

1. PLACE OF DEATH
a. COUNTY: None
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits: Yes ☑ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 26 St. Louis Chronic — Length of stay in 1b: 49 Days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: None
c. CITY OR TOWN: St. Louis — Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location): 2902 Russell — Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First: John Middle: L. Last: Hoffmann

4. DATE OF DEATH: Month: 9 Day: 30 Year: 1958

5. SEX: M

6. COLOR OR RACE: Wh.

7. MARRIED ☑ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 8/25/1888

9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired State Employee

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): St. Louis, Mo

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Jacob HOFFMAN

13b. MOTHER'S MAIDEN NAME: Margaret BERZEN

14. NAME OF ~~HUSBAND~~ OR WIFE: Augusta HOFFMANN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 489-18-9811

17. INFORMANT: Hosp. Record, 5800 Arsenal (Address)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Left Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 wks.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 491X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Old Cerebral Thrombosis c Left Hemiplegia - 49 days

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 8/12/58, to 9/30/58 and last saw him alive on 9/30/58
Death occurred at 9:15 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): John W. Beckham, M.D.

22b. ADDRESS: 5800 Arsenal

22c. DATE SIGNED: 9/30/58

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE: OCT 3 1958

23c. NAME OF CEMETERY OR CREMATORY: ST PETER & PAUL CEM

23d. LOCATION (City, town, or county) (State): ST. LOUIS MO

24. FUNERAL DIRECTOR: Thomas Kutis — ADDRESS: 2906 Gravois

25. DATE RECD. BY LOCAL REG.: OCT 2 '58

26. REGISTRAR'S SIGNATURE: Carl Smith MD M.D.

(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. 4347

P. O. Address 2906 [illegible]

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.