

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY WARREN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N. GRAND ST. LOUIS, MO.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN MARTHASVILLE Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
35 FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET. ADM. HOSPITAL		Length of stay in 1b 21 DAYS	d. STREET ADDRESS (If outside, give location) 31 Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last VIRGIL C HOFFMANN			4. DATE OF DEATH Month Day Year 10/24/58	
5. SEX MALE 0	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> 0 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/29/06	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		9b. KIND OF BUSINESS OR INDUSTRY UNKNOWN	9. AGE (In years at birthday) 51 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. FATHER'S NAME OTTO HOFFMANN		10b. MOTHER'S MAIDEN NAME EUGENIA KOCH		14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) YES WW-2		16. SOCIAL SECURITY NO. 486-20-9334	17. INFORMANT Address VAH RECORDS 915 N. GRAND ST. LOUIS, MO.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA LEFT RENAL CARCINOMA DUE TO (b) 180x DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 MONTHS
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 type="checkbox"/> NO <input checked="" type="checkbox"/> 2

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 WORK <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 10/3/58 to 10/24/58 and last saw him <sup>her</sup> alive on 10/24/58 Death occurred at 5:20 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE GERALD L. BEHE (Degree or title) <i>G. L. Behr</i>	22b. ADDRESS M.D. VAH ST. LOUIS, MISSOURI	22c. DATE SIGNED 10/24/58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/28/58	23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery	23d. LOCATION (City, town, or county) (State) Marthasville, Missouri
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24. FUNERAL DIRECTOR <i>S. F. Lechtenberg</i> ADDRESS Marthasville, Mo.	25. DATE RECD. BY LOCAL REG. OCT 27 '58	26. REGISTRAR'S SIGNATURE <i>J. Carl Smith, M.D.</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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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 *Edmond F. Zutterberg* .....

Licensed Embalmer No. ....4318.....

P. O. Address...Marthasville,..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.