

Health, Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-042835
STATE FILE NUMBER

FILED DEC 1 1958 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3068

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| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bonhomme Township</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | c. CITY OR TOWN <u>4000 Bonhomme Township</u> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Schoettler Rd.</u> | | Length of stay in lb <u>16 yrs.</u> | d. STREET ADDRESS (If outside, give location) <u>Schoettler Road</u> |
| Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |

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| 3. NAME OF DECEASED (Type or print) First <u>Frieda</u> Middle <u>Elizabeth</u> Last <u>HOFFMANN Mertz</u> | | | 4. DATE OF DEATH Month <u>11</u> Day <u>22</u> Year <u>58</u> | | |
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| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</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>May 17, 1903</u> | 9. AGE (In years last birthday) <u>55</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> | 11. BIRTHPLACE (City and state or country) <u>Creve Coeur, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
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| 13a. FATHER'S NAME <u>George Mertz</u> | 13b. MOTHER'S MAIDEN NAME <u>Elizabeth</u> | 14. NAME OF HUSBAND OR WIFE <u>August Hoffmann</u> |
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| 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 <u>Aug. Hoffmann, Chesterfield, Mo R#1</u> | Address |
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| 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>Carcinoma of Stomach</u> | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>with Generalized Metastasis</u> | |
| | DUE TO (c) <u>and Ascites 151X</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 type="checkbox"/> NO <input checked="" type="checkbox"/> |

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| 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.) |
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| 20c. TIME OF INJURY Hour <u> </u> Month, Day, Year a.m. <u> </u> p.m. <u> </u> | 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 |
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| 21. I attended the deceased from <u>July 8, 1958</u> , to <u>Nov. 18, 1958</u> and last saw her alive on <u>Nov. 18, 1958</u> Death occurred at <u>5 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | |
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| 22a. SIGNATURE (Degree or title) <u>Royal C. McKeon MD</u> | 22b. ADDRESS <u>Berkwood Mo</u> | 22c. DATE SIGNED <u>11-24-58</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>11/25/58</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Cemetery,</u> | 23d. LOCATION (City, town, or country) (State) <u>Clayton & Woods Mill Roads</u> |
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| 24. FUNERAL DIRECTOR <u>Schrader Funeral Home, Ballwin, Mo.</u> | ADDRESS | 25. DATE RECD. BY LOCAL REG. <u>11-24-58</u> | 26. REGISTRAR'S SIGNATURE <u>Herbert R. Klomke, Mo.</u> |
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 Bypp*

Licensed Embalmer No. *4584*

P. O. Address *Ballwin, 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.