

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023001

STATE FILE NUMBER

2-6229

Health,  
& Welfare  
Public  
Service

WED JUL 13 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

Registrar's Signature \_\_\_\_\_

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S. 300  
1-57  
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1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Madison</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>Collinsville</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Deaconess</b>		d. STREET ADDRESS (If outside, give location) <b>R.R. # 1</b>	
Length of stay in lb <b>15 days</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>HERMAN</b> Middle <b>ARTHUR</b> Last <b>HOFFMANN</b>			4. DATE OF DEATH Month <b>June</b> Day <b>29</b> Year <b>1959</b>		
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 26, 1889</b>	9. AGE (In years last birthday) <b>70</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>miner</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>coal</b>	11. BIRTHPLACE (City and state or country) <b>Collinsville, Illinois</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Gottlob Hoffmann</b>	13b. MOTHER'S MAIDEN NAME <b>Maria Lorenz</b>	14. NAME OF HUSBAND OR WIFE <b>Florence Hoffmann</b>
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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) <b>yes World War I</b>	16. SOCIAL SECURITY NO. <b>343-05-8403</b>	17. INFORMANT <b>Mrs. Florence Hoffmann Ill.</b>	Address <b>Collinsville,</b>
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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) <b>UREMIA</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>?</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>ARTERIOULAR Nephrosclerosis</b>	
	DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Acute LOBAR PNEUMONIA. 446X</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <b>ITEM 21 CORRECTED BY AFFIDAVIT OF Physician 7-27-59 DEJ</b>
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE WORK AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>June</b>	20f. CITY, TOWN, OR LOCATION <b>June</b>	COUNTY _____ STATE _____
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21. I attended the deceased from **Jan 1 1959** to **July 29 1959** and last saw <sup>her</sup> him alive on **July 29, 1959**  
Death occurred at **8:25 PM** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>John J. Roth M.D.</b>	22b. ADDRESS <b>634 N. Grand Blvd. ST. Louis Mo.</b>	22c. DATE SIGNED <b>6/30/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>7/2/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Collinsville, Illinois</b>
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24. FUNERAL DIRECTOR <b>Herr Funeral Home</b>	ADDRESS <b>Collinsville, Ill.</b>	25. DATE RECD. BY LOCAL REG. <b>JUL 1 '59</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>
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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

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 x  
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 4.2.9  
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 1111

**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 *W. H. Shaw Jr* .....  
 Licensed Embalmer No. 3577 .....  
 P. O. Address *Collinsville, 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.