

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028740

FILED VS SEP 8 1959

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 931

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Missouri</u> , b. COUNTY <u>Polk</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Length of stay in lb <u>34 1/2 days</u>		c. CITY OR TOWN <u>Bolivar</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Ozark Osteopathic</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Rte # 4</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Umpfrey</u> Middle <u>Sialas</u> Last <u>Hoffer</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>9</u> Year <u>1959</u>				
5. SEX <u>Male</u>	6. COLOR OF 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>2-13-1881</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Gen farming</u>		11. BIRTHPLACE (City and state or country) <u>Atton, Ill.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Jacob Hoffer</u>			13b. MOTHER'S MAIDEN NAME <u>Carrie Miller</u>		14. NAME OF HUSBAND OR WIFE <u>Claudius Hoffer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT Address <u>Mrs. Wayne Hoffer Bolivar, Mo.</u>				
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>Respiratory Failure</u>							INTERVAL BETWEEN ONSET AND DEATH <u>12 h</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>cerebral thrombosis</u>							<u>36 h.</u>	
DUE TO (c) <u>cardiac decompensation</u>							<u>48 h.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>diabetic + severe metabolic disturbance</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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.)				
20c. TIME OF INJURY Hour <u> </u> Month, Day, Year <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		
21. I attended the deceased from <u>July 30, 1959</u> to <u>9-2-59</u> and last saw ^{her} him _{alive} on <u>9-2-59</u> Death occurred at <u>11:10 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Andrew Martiniuk, MD</u>				22b. ADDRESS <u>Springfield Mo.</u>		22c. DATE SIGNED <u>9-2-59</u> (State)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept 5 - 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>		23d. LOCATION (City, town, or county) <u>Bolivar</u>		23e. REGISTERAR'S SIGNATURE <u>Wm</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Pitts F. H - Bolivar, Mo</u>			25. DATE RECD. BY LOCAL REG. <u>9-4-59</u>		26. REGISTRAR'S SIGNATURE <u>Effie G. Melton</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Shelby J. Pitts

Licensed Embalmer No. 4939

P. O. Address Bol. 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.