

**FEDERAL BUREAU OF INVESTIGATION
DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

59-035591

FILED VS OCT 19 1959

STATE FILE NUMBER

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 279

ENDED

1. PLACE OF DEATH a. COUNTY <u>Cole</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Osage</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jefferson City</u>		Length of stay in 1b <u>24 hrs</u>	c. CITY OR TOWN <u>Freeburg</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Marys' Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>FRITZ</u> Middle <u>Hoffman</u> Last <u>Hoffman</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>15</u> Year <u>1959</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8/25/1881</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>10</u> 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>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Freeburg Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Mike Hoffman</u>		13b. MOTHER'S MAIDEN NAME <u>Cunigunda Kloeppel</u>		14. NAME OF HUSBAND OR WIFE <u>Elizebeth Hartman Dec.</u>	
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.		17. INFORMANT <u>Mrs Leo B Lock</u> Address <u>Freeburg 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>Cerebral Hemorrhage</u>					INTERVAL BETWEEN ONSET AND DEATH <u>26 hrs</u>
DUE TO (b) <u>Falling down stairs, landing on his head</u>					
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Falling down stairs, landing on his head at his home</u>			
20c. TIME OF INJURY Hour <u>3:30</u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u>Oct. 14/59</u>					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>at home</u>	20f. CITY, TOWN, OR LOCATION <u>Freeburg</u>	COUNTY <u>Osage</u>	STATE <u>Mo</u>	
21. I attended the deceased from _____, to _____, and last saw ^{her} him alive on _____. Death occurred at <u>October 15/59 - 8:45 Pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>Coroner</u>			22b. ADDRESS <u>Linn Mo.</u>		22c. DATE SIGNED <u>10/17/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>10/19/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy F. mly Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Freeburg Mo</u>		
24. FUNERAL DIRECTOR <u>Clyde Morton</u> ADDRESS <u>Linn Mo</u>		25. DATE RECD. BY LOCAL REG. <u>17 October 1959</u>	26. REGISTRAR'S SIGNATURE <u>R.P. Norris, mrs - M. Richter, Reg.</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 Omer H. Jones

Licensed Embalmer No. 4411

P. O. Address Belle Meade

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.