

JURI DIVISION OF HEALTH—STANDARD CERTIFICATE OF DEATH

'59 0 4 5 5 5 6

FILED VS DEC 21 1959

211314

STATE FILE NUMBER

ENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 80 years	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Alexian Bros. Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4421 Gravois Avenue		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First LOUIS Middle C. Last HOFF			4. DATE OF DEATH Month December Day 5 , Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/3/79	9. AGE (last birthday) 80 yrs.	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Turnkey		10b. KIND OF BUSINESS OR INDUSTRY City Jail, St. Louis		11. BIRTHPLACE (City and state or country) Chicago, Ill.	
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Louis G. Hoff		13b. MOTHER'S MAIDEN NAME Amelia (Unknown)	
14. NAME OF HUSBAND OR WIFE Mrs. Lena Hagemann Hoff		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 493-07-3064	
17. INFORMANT Miss Alvera Hoff, 4421 Gravois Avenue		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leukemia DUE TO (b) Prostatectomy DUE TO (c) 610x Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hypertension			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 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 _____ a.m. _____ p.m. Month, Day, Year _____	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 Nov 22, 1959 to Dec 5, 1959 and last saw her alive on Dec 4, 1959 Death occurred at 8:00 A. m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE [Signature] (Degree or title) M.D.		22b. ADDRESS 6500 Chippewa	22c. DATE SIGNED 12-7-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Dec. 7, 1959	23c. NAME OF CEMETERY OR CREMATORY St. Trinity Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri.		
24. FUNERAL DIRECTOR Beiderwieden F.H.Inc., 1936 St. Louis		25. DATE RECD. BY LOCAL REG. DEC 7 1959	26. REGISTRAR'S SIGNATURE [Signature]		

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 _____

Licensed Embalmer No. 453

P. O. Address Albany

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.