

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
 FILED VS DEC 21 1959

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211256

STATE FILE NUMBER

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)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis Chronic Hosp.</b>		d. STREET ADDRESS (If outside, give location) <b>6164 Carlsbad Ave.</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First	Middle	Last	Month	Day	Year
<b>Johanna Hoffman</b>			<b>December 2, 1959</b>		
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR IF UNDER 24 HR
<b>Female</b>	<b>White</b>		<b>2/18/1870</b>	<b>89</b>	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)	
<b>Housewife</b>		<b>Home</b>		<b>Saxomy, Germany</b>	
12. CITIZEN OF WHAT COUNTRY		13. FATHER'S NAME			
<b>U.S.</b>		<b>Julius Hoffman</b>			
13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE			
<b>Agusta Stingler</b>		<b>unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <input type="checkbox"/> or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
<b>No</b>		<b>unknown</b>		<b>Mr. Hannis Clearview Rest Home</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Fractured Right Hip</b>		
DUE TO (b) <b>Generalized Arteriosclerosis</b>		
DUE TO (c) <b>904.7 45</b>		
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 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>Suffered in fall on</b>	
20c. TIME OF INJURY Hour: <b>3</b> a.m. p.m.	Month, Day, Year <b>9 25 59 9. 25. 59</b>	<b>at 5600 Arsenal St</b>	
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
	<b>131 Nap</b>	<b>St Louis Mo</b>	<b>Mo</b>
21. I attended the deceased from _____ and last saw her/him alive on _____ Death occurred at <b>1050 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) <b>Patricia Taylor Carauer</b>		22b. ADDRESS <b>1300 Clark</b>	22c. DATE SIGNED <b>12. 4. 59.</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12/7/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Normandy, Missouri</b>
24. FUNERAL DIRECTOR <b>Morrell Mortuary</b>	ADDRESS <b>3710 North Grand Blvd</b>	25. DATE RECD. BY LOCAL REG. <b>DEC 4 1959</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*mjs*

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_, or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_, working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Laron E. Serc

Licensed Embalmer No. 408

P. O. Address S. S. Lou

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.