# URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS MAR 8 1960

2 2314 -60-008358
STATE FILE NUMBER

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

NDED

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Length of stay in 1b: years

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 4130 East Carter Avenue — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri — b. COUNTY:

c. CITY OR TOWN: St. Louis — Inside Limits: Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location): 4130 East Carter Avenue — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First HERMAN — Middle E. — Last HOFFMAN

4. DATE OF DEATH: Month February — Day 27, — Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 6-10-1911

9. AGE (last birthday): 48 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HR: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Service Man

10b. KIND OF BUSINESS OR INDUSTRY: Laclede Gas Co.

11. BIRTHPLACE (City and state or country): St. Louis, Missouri

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Herman Hoffman

13b. MOTHER'S MAIDEN NAME: Hope Whitacre

14. NAME OF HUSBAND OR WIFE: Frances Hoffman

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.: 487-18-4278

17. INFORMANT — Address: Mrs. Frances Hoffman - 4130 E. Carter Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): acute Myocardial Failure

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 420.1

INTERVAL BETWEEN ONSET AND DEATH

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 10-14-59, to 2-26-60 and last saw her/him alive on 2-26-60
Death occurred at 11 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): H E Morris M D

22b. ADDRESS: 4110 W Florissant ave

22c. DATE SIGNED: 2-27-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: March 2, 1960

23c. NAME OF CEMETERY OR CREMATORY: Memorial Park Cemetery

23d. LOCATION (City, town, or county) (State): St. Louis County, Missouri

24. FUNERAL DIRECTOR — ADDRESS: Math Hermann & Son, Inc., 2161 E. Fair

25. DATE RECD. BY LOCAL REG.: FEB 29 1960

26. REGISTRAR'S SIGNATURE: Carl Smith, M.D.
MJB

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DOCUMENT

Queried: - Underlying Cause: Coronary art. dis

**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 Wilford G Burnley

Licensed Embalmer No. 4202

P. O. Address Hyrum

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