

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 2 1960 318

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-60-032340

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **8069** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>ST. LOUIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Length of stay in 1b	c. CITY OR TOWN <b>PINE LAWN</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3531 ARDEN</b>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>B.</b> Last <b>HOFFMAN</b>			4. DATE OF DEATH Month <b>AUGUST</b> Day <b>14</b> Year <b>1960</b>		
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5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12-5-1905</b>	9. AGE (last birthday) <b>54</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	11. BIRTHPLACE (City and state or country) <b>SIGEL ILL.</b>	12. CITIZEN OF WHAT COUNTRY <b>U S A</b>
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13a. FATHER'S NAME <b>JOHN BERCHTOLD</b>	13b. MOTHER'S MAIDEN NAME <b>BERTHA WILSON</b>	14. NAME OF HUSBAND OR WIFE <b>ALBERT A. HOFFMAN</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>ALBERT A. HOFFMAN 3531 ARDEN</b>
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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>ANURIA</b>		<b>24 HOURS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>URETERAL OBSTRUCTION</b>	<b>FEW DAYS</b>
	DUE TO (c) <b>UNDIFFERENTIATED CARCINOMA OF RETROPERINEUM</b>	<b>6 MONTHS</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>158x</b>				

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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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
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21. I attended the deceased from **JAN. 10, 1937** to **AUG. 14, 1960** and last saw her alive on **AUG. 14, 1960**  
 Death occurred at **11:25 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>C. O. Vermillion, M.D.</i>	(Degree or title) <b>M. D.</b>	22b. ADDRESS <b>BARNES HOSPITAL</b>	22c. DATE SIGNED <b>8/15/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>8-17-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CALVARY CEMETERY</b>	23d. LOCATION (City, town, or county) <b>ST. LOUIS, MO.</b>
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24. FUNERAL DIRECTOR <b>STROOT CARROLL 4600 NATURAL BRIDGE</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>AUG 16 1960</b>	26. REGISTRAR'S SIGNATURE <i>Roan Smith, M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

BARRETT HOSPITAL

**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

*M W Rueter*

Licensed Embalmer No. \_\_\_\_\_

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P. O. Address \_\_\_\_\_

St Louis

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.