

INDEXED

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		c. CITY OR TOWN	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location)	

ST. LOUIS MO ST. LOUIS MO 2835 S. JEFFERSON 2835 S. JEFFERSON

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
5. SEX			6. COLOR OR RACE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR	
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)	

FRED J. HOFFMANN AUG. 24 1960 MALE WHITE Widowed Divorced JULY 2 1886 74 RETIRED STOCK CLERK MO U.S.A.

13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	

HENRY HOFFMANN CATHERINE EBANRECK EVELYN HOFFMANN NO. 487-22-5556 EVELYN HOFFMANN S. JEFFERSON 2835 S.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a)			
DUE TO (b)			
DUE TO (c)			

Abdominal and pulmonary metastatic adenocarcinoma Adenocarcinoma of transverse colon Adenocarcinoma of Transverse Colon 1 yr 5 yrs

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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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153.1

20c. TIME OF INJURY		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	

July 1960 August 24 1960

21. I attended the deceased from July 9A. to August 13, 1960 and last saw him alive on Aug. 13, '60. Death occurred at 9A. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)		22b. ADDRESS		22c. DATE SIGNED	
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Frank L. Coyle, M.D. 1325 S. Grand 1325 So. Grand, St. Louis 8/25/60

23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION (City, town, or county)		(State)			

BURIAL AUG. 26 1960 RESURRECTION CEM. ST. LOUIS CO, MO

24. FUNERAL DIRECTOR ADDRESS		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE	
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Thomas Kutsa 2916 Garvin AUG 25 1960 Road Smith. M.D.

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

Eleana Province

Licensed Embalmer No. 3403

P. O. Address 2906 Grav

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.