

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 21 1960

-60-046888

STATE FILE NUMBER

Registration District No. 230. Primary Registration District No. 5810. Registrar's No. 17.

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| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>MONTG.</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LOUTRE</u> | | c. CITY OR TOWN <u>ALL HIS LIFE</u> | |
| Length of stay in 'b' <u>ALL HIS LIFE</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SO. MONTG. COUNTY</u> | | d. STREET ADDRESS (If outside, give location) <u>Southern Montg. County</u> | |
| Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |

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|--|---------------------------|---|--|--|---|
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>WILBERT CHRISTIAN HOFFMAN</u> | | | 4. DATE OF DEATH Month Day Year <u>12-18-1960</u> | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-6-1920</u> | 9. AGE (last birthday) <u>40</u> | 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) <u>FARMING</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u> | | 11. BIRTHPLACE (City and state or country) <u>RHINELAND, MO.</u> | |
| 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u> | | 13a. FATHER'S NAME <u>OTTO HOFFMAN</u> | | 13b. MOTHER'S MAIDEN NAME <u>CLARA HOLZUM</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>LORENE</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>497-18-4419</u> | |
| 17. INFORMANT Address <u>Lorene Hoffman - Rhineland, Mo.</u> | | 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) Broken Neck + Skull Fracture

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) _____

DUE TO (c) _____

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

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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input checked="" 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 Month, Day, Year a.m. p.m. | | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 _____ to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

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|---|---------------------------|--|---|----------------------------------|
| 22a. SIGNATURE (Degree or title) <u>F. J. Ball</u> Coroner. | | 22b. ADDRESS <u>Jonesburg, Missouri.</u> | | 22c. DATE SIGNED <u>12/18/60</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>12/21/60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's</u> | 23d. LOCATION (City, town, or county) <u>Rhineland, Mo.</u> | |

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| 24. FUNERAL DIRECTOR <u>Kottmeyer & Co. Rhineland, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>Dec. 19 - 1960.</u> | 26. REGISTRAR'S SIGNATURE <u>Mrs. Eunice Bush.</u> |
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(Licensed Embalmer's Statement on Reverse Side)

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed D B Baker

Licensed Embalmer No. 3375

P. O. Address New Florence, Mo

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.

03-21-11