MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-010992
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2310

FILED MAR 23 1961

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS
Length of stay in Ib: LIFE
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST. LUKE'S-HOSPITAL
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): 1446-BENTON-ST.
Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First FRIEDA – Middle J. – Last HOFFMAN
4. DATE OF DEATH: Month MARCH. Day 8TH. Year 1961
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐
8. DATE OF BIRTH: 10-4-1897
9. AGE (last birthday): 63 YRS.
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): (FORMERLY) COOK
10b. KIND OF BUSINESS OR INDUSTRY: KAUFMANN-BOX LUNCH-CO.
11. BIRTHPLACE (City and state or country): ST. LOUIS-MO.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: WILLIAM-RASCHE
13b. MOTHER'S MAIDEN NAME: MARIE-FRANKE
14. NAME OF HUSBAND OR WIFE: GLEN-HOFFMAN (DECD.)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): NONE
17. INFORMANT: ALBERT P. STROBLE
Address: 1446-BENTON-ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Coronary thrombosis
DUE TO (c): Arteriosclerotic heart disease
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): None 420.0
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.): None
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.): None
20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from 3-6-61, to 3-8-61 and last saw her/him alive on 3-8-61
Death occurred at 10 00 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title): H. Robert Bowles, M.D.
22b. ADDRESS: St. Luke's Hospital 5535 Delmar, St. Louis, Mo.
22c. DATE SIGNED: 3-8-61
23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE: MAR. 10-1961
23c. NAME OF CEMETERY OR CREMATORY: FRIEDEN'S-CEMETERY.
23d. LOCATION (City, town, or county) (State): ST. LOUIS (COUNTY) MO.
24. FUNERAL DIRECTOR: Brockland Und. Co.
ADDRESS: 1827-HOGAN-ST.
25. DATE RECD. BY LOCAL REG.: MAR 9 1961
26. REGISTRAR'S SIGNATURE: Earl Smith M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

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 Harvey Kahle

Licensed Embalmer No. 4596

P. O. Address St Louis, 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.