

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-029334

STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3909

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kans.</u> b. COUNTY <u>Johnson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas city</u>		Length of stay in 1b <u>1 week</u>	c. CITY OR TOWN <u>Overland Park</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Luke's Hosp</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>6417 W 67</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Edward</u> Last <u>Hoffman</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>5</u> Year <u>1961</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</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>Aug 12 1902</u>	9. AGE (last birthday) <u>58</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractors Superintendent - Home Construction - Overland Park, Mo</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>	12. CITIZEN OF WHAT COUNTRY <u> </u>	

13a. FATHER'S NAME <u>Isiah C. Hoffman</u>	13b. MOTHER'S MAIDEN NAME <u>Ida Henderson</u>	14. NAME OF HUSBAND OR WIFE <u>Florence Hoffman</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>		17. INFORMANT <u>Mrs Florence Hoffman</u> Address <u>6417 W 67st Overland Park, Mo</u>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure secondary to abdominal carcinomas</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u> </u>	
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

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.) <u> </u>
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u>		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.) <u> </u>		20f. CITY, TOWN, OR LOCATION <u> </u> COUNTY <u> </u> STATE <u> </u>

21. I attended the deceased from 8-3-61 to 8-4-61 and last saw her/him alive on 8-4-61
Death occurred at 1:05 AM on 8-5-61 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Waldo S. Holt</u> (Doctor or title)	22b. ADDRESS <u>WALDO S. HOLT, M. D. 4620 NICHOLS PARKWAY</u>	22c. DATE SIGNED <u>8-5-61</u>
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Aug 7 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Jo. C. Mem. Gardens</u>
23d. LOCATION (City, town, or county) <u>Overland Park, Kans.</u>	24. FUNERAL DIRECTOR <u>Wilburn Hoge, Overland Park, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>8-7-61</u>
26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>		

DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
ITEM NO. SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
Waldo S. Holt

6028

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 J. Royce Hoge

Licensed Embalmer No. 3579

P. O. Address Wabon Paul K

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.