

# SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-044766  
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6533

AMENDED

DATE AMENDED

INSTEAD OF

DOCUMENT

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>Jackson</b>	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>	a. STATE <b>Mo</b>	b. COUNTY <b>Jackson</b>
Length of stay in 1b <b>41 yrs</b>		c. CITY OR TOWN <b>Kansas City</b>	Inside Limits Y <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>5703 Bennington</b>		d. STREET ADDRESS <b>5703 Bennington</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH	
First <b>ALBERT</b>	Middle <b>B</b>	Last <b>HOFFER</b>	Month <b>12</b>	Day <b>26</b>
Year <b>1962</b>				
5. SEX <b>Male</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>2/21/1880</b>	9. AGE (last birthday) <b>81</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Mfg. Representative</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Std. Pressed Steel Co Carlisle, Pa</b>	11. BIRTHPLACE (City and state or country) <b>U S A</b>	12. CITIZEN OF WHAT COUNTRY <b>U S A</b>
13a. FATHER'S NAME <b>Unknown Hoffer</b>		13b. MOTHER'S MAIDEN NAME <b>Lillian Boas</b>		14. NAME OF HUSBAND OR WIFE <b>Pauline Teale Hoffer</b>

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  
**no**

17. INFORMANT Address  
**Mrs. Pauline Hoffer, 5703 Bennington**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)	<b>acute pulmonary edema</b>	INTERVAL BETWEEN ONSET AND DEATH	<b>2 hrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	<b>congestive Heart failure</b>	<b>10 yrs</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

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.)
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year	
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

21. I attended the deceased from 12-12-61 to 12-36-61 and last saw <sup>her</sup>him alive on 12-26-61  
Death occurred at 9:00 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Elmer G. Stepmar, M.D.</b>	22b. ADDRESS <b>Raytown, Mo</b>	22c. DATE SIGNED <b>12-27-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12/29/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Moriah</b>
23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>		

24. FUNERAL DIRECTOR ADDRESS <b>Sheil Colonial Funeral Home K C Mo</b>	25. DATE RECD. BY LOCAL REG. <b>12-28-61</b>	26. REGISTRARS SIGNATURE <b>Ruth Long</b>
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MEDICAL CERTIFICATION

BY AFFIDAVIT OF  
**Elmer G. Stepmar**

ITEM NO. SHOULD READ

**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 John P. Shiel

Licensed Embalmer No. 3625

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.