

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

3754 -62-016890
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3754

FILED APR 25 1962

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Louis, Mo.</u>		Length of stay in 1b <u>30 Yrs.</u>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. Pacific Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1729 So 11th St</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Francis</u> Middle <u>Vincent</u> Last <u>Hoffman</u>			4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1962</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>11-4-1904</u>
9. AGE (last birthday) <u>57</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>Baggage Handler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Terminal R.R.</u>	11. BIRTHPLACE (City and state or country) <u>Perryville, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>George Hoffman</u>	
13b. MOTHER'S MAIDEN NAME <u>Marie Tucker</u>		14. NAME OF HUSBAND OR WIFE <u>wife- Marie</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>[redacted]</u>	
17. INFORMANT <u>Marie Hoffman, 1729 S. 11th</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cor Pulmonale.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Emphysema chronic bronchitis.</u> DUE TO (c) <u>502.0</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>1 yrs.</u>
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <u>Feb. 1959</u> to <u>April 9, 1962</u> and last saw him alive on <u>March 29, 1962</u> Death occurred at <u>3 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.*			
22a. SIGNATURE <u>E. R. Sheridan, M.D.</u> (Degree or title)		22b. ADDRESS <u>1755 So Grand Blvd</u>	22c. DATE SIGNED <u>4-9-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4/13/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Matthews Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
24. FUNERAL DIRECTOR <u>McLaughlin</u>		ADDRESS <u>2301 Lafayette Ave</u>	25. DATE RECD. BY LOCAL REG. <u>APR 10 1962</u>
26. REGISTRAR'S SIGNATURE <u>Carl Smith, M.D.</u>			

USE BLACK INK OR TYPEWRITER RIBBON

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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 A. G. Farris

Licensed Embalmer No. 3384

P. O. Address A. Farris

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.