

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-019916

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 142 Primary Registration District No. 423/ Registrar's No. 24

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0460

2 04601

3

4 0

5 1

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7 1

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9 4200

10

11

12 2-0

13 4-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED JUN 4 1963

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: <u>Mo.</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mtn. View</u>		c. CITY OR TOWN <u>Mtn. View Rural</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>St. Francis Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rt. 2 Box 141</u>
3. NAME OF DECEASED (Type or print) First <u>Leroy</u> Middle <u>Carl</u> Last <u>Hoff</u>		4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>1963</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>4/18/90</u>
9. AGE (last birthday) <u>73</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supv. of schools</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Carroll Co. Ind.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Joseph Wm. Hoff</u>	
13b. MOTHER'S MAIDEN NAME <u>Martha E. Graham</u>		14. NAME OF HUSBAND OR WIFE <u>Carrie E. Hoff</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv.) <u>no</u>		17. INFORMANT <u>Carrie E. Hoff</u> Address <u>Mtn. View, 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>Pulmonary edema</u> DUE TO (b) <u>Post myocardial infarction</u> DUE TO (c) <u>Arteriosclerotic heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>interventricular septal defect</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.)	
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 checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>Mtn. View, Mo.</u>	
20g. COUNTY		20h. STATE	
21. I attended the deceased from <u>Jan 1963</u> to <u>May 23</u> and last saw her/him alive on <u>May 23</u> Death occurred at <u>May 23, 1963</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>M.C. Walton M.D.</u> (Degree or title)		22b. ADDRESS <u>Mtn. View, Mo.</u>	
22c. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>5/26/63</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Mtn. View, Missouri</u>	
24. FUNERAL DIRECTOR <u>Duncom Funeral Home</u> ADDRESS <u>Mtn. View, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>5-28-1963</u>	
26. REGISTRAR'S SIGNATURE <u>Charles D. Cartain</u>			

USE BLACK INK OR TYPEWRITER RIBBON

To Doctor: 12: Noon 5/24/63 E96L 6 T NNC

Rec'd from Dr. 11: A.M. 5/27/63

To Local Reg. 11: A.M. 5/27/63

Burial Permit issued 5-26-1963

E96L 8 T NNC

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

Charles D. Carter

Licensed Embalmer No. 5187

P. O. Address Wm. Lewis 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.