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FILED APR 6 1947

Primary Registration District No. 3040

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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH: *Burlington*

(a) County *Burlington*

(b) City or town *Chillicothe*
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: *Chillicothe Hospital*
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution *6 wks.* (Specify whether
In this community *Six months* years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Missouri* (b) County *Burlington*

(c) City or town *Rural* (If outside city or town limits, write "RURAL")

(d) Street No. *Ray Co Rural* (If rural, give location)

(e) Citizen of foreign country? *No* (Yes or No)

If yes, name country *—*

3. (a) PRINT FULL NAME *Element J Hoffman*

3. (b) If veteran, name war *—*

3. (c) Social Security No. *—*

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Mar.* day *8th* year *1944* hour *10* minute *- A.M.*

4. Sex *Male* 5. Color or race *White*

6. (a) Single, widowed, married, divorced *married*

6. (b) Name of husband or wife *Ida Hoffman* 6. (c) Age of husband or wife if alive *74* years

7. Birth date of deceased *Mar 20 1863*
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from *Jan 25 1944* to *March 8 1944* that I last saw him alive on *March 8 1944* and that death occurred on the date and hour stated above.

8. AGE: Years *80* Months *11* Days *13* If less than one day *—* hr. *—* min.

Immediate cause of death *Cerebral Thrombosis* Duration *45 days*

9. Birthplace *Lancaster Ohio*
(City, town, or county) (State or foreign country)

Due to *—*

Due to *—*

10. Usual occupation *Farmer Ret.*

Other conditions (include pregnancy within 3 months of death) *83 l*

11. Industry or business *General farming*

Major findings: Of operations *—*

12. Name *William Hoffman*

Of autopsy *—*

13. Birthplace *Lancaster Ohio*
(City, town, or county) (State or foreign country)

14. Maiden name *Janet Williamson*

15. Birthplace *Lancaster Ohio*
(City, town, or county) (State or foreign country)

16. (a) Informant *Olive C. Peery*

(b) Address *Chillicothe Mo.*

17. (a) *Burial* (b) Date thereof *Mar 10 1944*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Leaugill Cem*

18. (a) Signature of funeral director *James D. Gordon*

(b) Address *Chillicothe Mo.*

19. (a) *March 10* (b) *W. E. E. C. O. R. Y.*
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) *—*

(b) Date of occurrence *—*

(c) Where did injury occur? (City or town) (County) (State) *—*

(d) Did injury occur in or about home, on farm, in industrial place, in public place? *—*

While at work? (Specify type of place) (e) Means of injury *—*

23. Signature *W. E. E. C. O. R. Y.* (M. D. or other) *—*

Address *Chillicothe Mo.* Date signed *March 10 1944*

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

.....; Registered Apprentice No.....
working under my personal supervision.

Signed.....

James D Gordon

Licensed Embalmer No. *1870*

P. O. Address *Chillicothe, 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 this body is not embalmed, fact should be so stated above.