

**FILED** APR 22 1946

Registration District No. \_\_\_\_\_

Primary Registration District No. 5279

Registrar's No. 34

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

**1. PLACE OF DEATH:**  
 (a) County Clark  
 (b) City or town Rural Jefferson Twp  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_  
years, months or days

**3. (a) PRINT FULL NAME** Jacob A. Hoff  
 3. (b) If veteran name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Marion J. Willing  
 6. (c) Age of husband or wife if alive 72 years  
 7. Birth date of deceased May 26 1870  
(Month) (Day) (Year)

**8. AGE:**  
 Years 75 Months 9 Days 10  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Clark Co. Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business \_\_\_\_\_

**MOTHER FATHER**  
 12. Name James Hoff  
 13. Birthplace England  
(City, town, or county) (State or foreign country)  
 14. Maiden name Elizabeth Parsons  
 15. Birthplace A  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Jacob A. Hoff

(b) Address Lacey Mo R.R.

17. (a) Burial (b) Date thereof 3-8-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chamberlayne

18. (a) Signature of funeral director Good Stacker

(b) Address Kahoka Mo

19. (a) 4/10-46 (b) J. Hoff  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Clark  
 (c) City or town Rural Jefferson Twp  
(If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No) \_\_\_\_\_  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month March day 6  
 year 1946 hour 11:45 minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from Jan 1 1942 to March 6 1946  
 that I last saw him alive on March 6 1946  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Cerebral Pustule  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy SIX

**PHYSICIAN**  
 \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

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) (b) Means of injury 0

23. Signature J. L. McEwell (M. D. or other) \_\_\_\_\_  
 Address Reverse Mo Date signed 3/11/46

RECEIVED

District Health Officer No. 10,

District File Number 4-46-771

Date Filed APR 19 1946

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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.....

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

Signed.....

Licensed Embalmer No. 1023

P. O. Address Kabota 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.**