

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38680

FILED NOV 23 1955

State File No.

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

Registrar's No. **9918**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Firmin DesLoge Hosp.		e. STREET ADDRESS (If rural, give location) 15 5408 So. Broadway	
3. NAME OF DECEASED (Type or Print) a. (First) Mollie b. (Middle) c. (Last) Neubauer		4. DATE OF DEATH (Month) (Day) (Year) 11 12 55	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jan. 16, 1873
9. AGE (In years last birthday) 82		10. MONTHS 9	11. DAYS 26
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (City and State or Foreign Country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Jacob Hoffmann		13b. MOTHER'S MAIDEN NAME Eva Koebel	
14. NAME OF HUSBAND/OR WIFE William Hoffmann (Deceased)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Irene Brocksmith		ADDRESS 553 a Bates	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of the stomach ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 151X	
19a. DATE OF OPERATION 11-4-55		19b. MAJOR FINDINGS OF OPERATION Carcinoma of stomach with metastases.	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11-1 , 1955, to 11-12 , 1955, that I last saw the deceased alive on 11-12 , 1955, and that death occurred at 3:21 a.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Valley H. Hallman M.D.		23b. ADDRESS 1402 S. Grand St. Louis	
23c. DATE SIGNED 11-14-55			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Nov. 15, 1955	
24c. NAME OF CEMETERY OR CREMATORY Park Lawn Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, County, Mo.	
DATE REC'D BY LOCAL REG. NOV 14 1955		25. FUNERAL DIRECTOR'S SIGNATURE Wm. Schumacher	
REGISTRAR'S SIGNATURE J. Carl Smith M.D.		ADDRESS 3013 Meramec St.	

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

Licensed Embalmer No. 479

P. O. Address St Louis

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.