

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

19610

1. PLACE OF DEATH

County..... Registration District No. 781
 Township..... Primary Registration District No. 1003
 City St. Louis (No. Jewish Hosp) St. _____ Ward)

2. FULL NAME

(a) Residence. No. 6250 North Drive St. 12 Ward. St. Louis Co. Mo.
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Mamie Cohen</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>May 8, 1875</u>		
7. AGE	YEARS	MONTHS
	<u>54</u>	<u>0</u>
		DAYS
		<u>1</u>
8. OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work <u>Auto Tires</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		
9. BIRTHPLACE (CITY OR TOWN) <u>Leeds</u> (STATE OR COUNTRY) <u>England</u>		
PARENTS	10. NAME OF FATHER <u>Morris Cohen</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Russia</u> (STATE OR COUNTRY)	
	12. MAIDEN NAME OF MOTHER <u>Annie Cohen</u>	
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Russia</u> (STATE OR COUNTRY)		
14. INFORMANT <u>Lee Cohen</u> (Address) <u>6250 N. Drive</u>		
15. FILED <u>MAY -9 1929</u> <u>May C Stanley</u> REGISTRAR		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 9 1929

17. I HEREBY CERTIFY, That I attended deceased from April 20, 1929, to May 9, 1929, that I last saw him alive on May 8, 1929, and that death occurred, on the date stated above, at 12:10 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Nephritis
(uræmia)

(duration) yrs. mos. ds.
13 1/2 0

CONTRIBUTORY (SECONDARY)
12 9 0
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH? No... DATE OF.....
 WAS THERE AN AUTOPSY? No

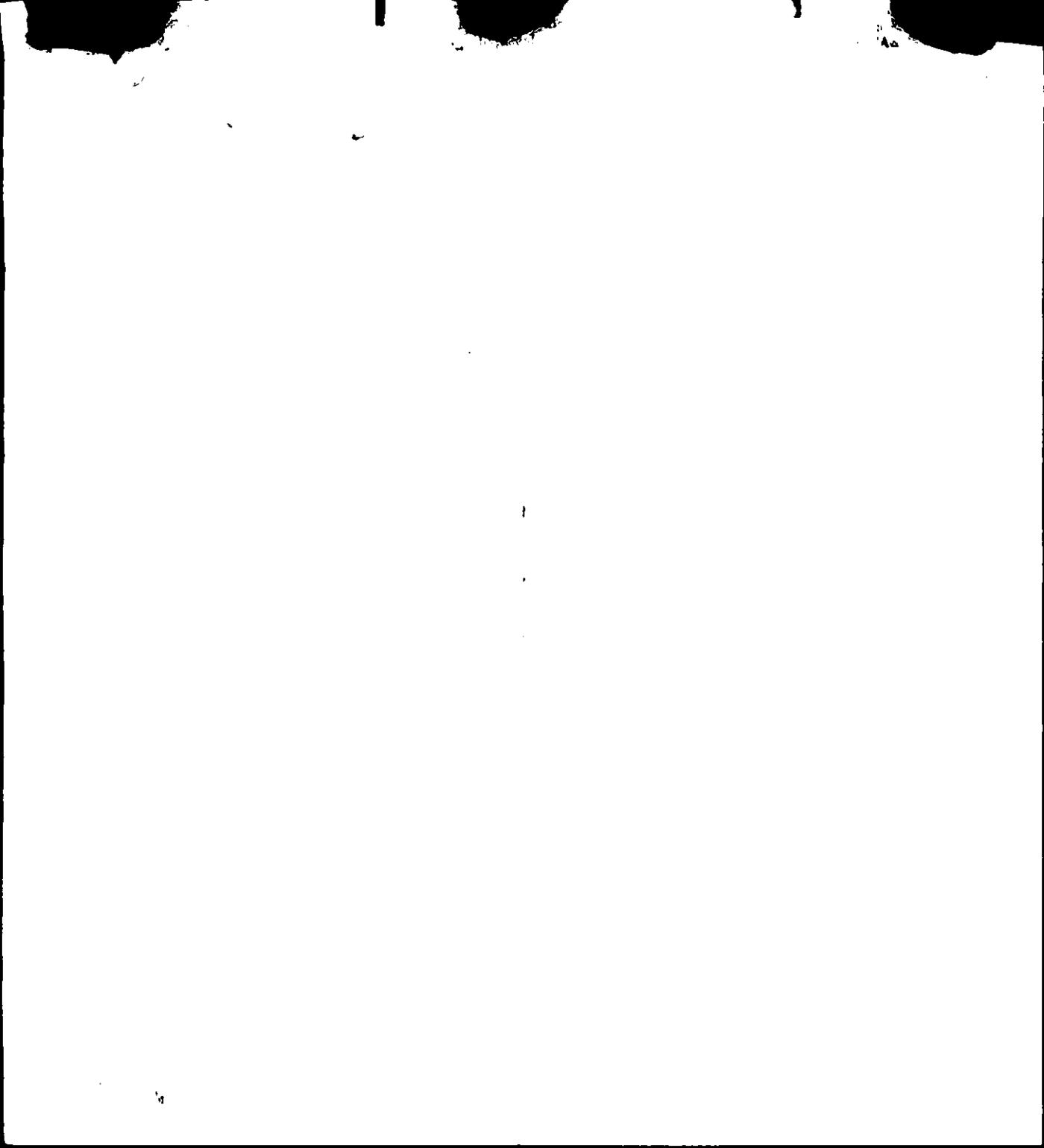
WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) Jerome C. Cook, M. D.
May 9 1929 (Address) Metropolitan Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Chester Shel Emeth DATE OF BURIAL 5/10 1929

20. UNDERTAKER A B Berger ADDRESS 4715 McPherson

This item of information should be carefully supplied. DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Registration District No. 791
 Township Primary Registration District No. 1008
 City St. Louis St. Jewish (Ward)
Ward

2. FULL NAME

(a) Residence. No. Jacob Cohen St. Jewish Ward. (If nonresident give city or town and State)
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 27, 1896

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
52 4 12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. da.
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT Leo Cohen
 (Address) 6200 N. Olive

15. FILED MAY 11 1929 May C Starling REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 9 1929

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19..... that I last saw him alive on 19....., and that death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) M. D. , 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20. UNDERTAKER H. B. Berger ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

F. S. S. SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY

SUPPLEMENTARY

1929
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