

REC'D DEC 14 1938

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

38096
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 399
 (b) Township Kaw Primary Registration District No. 100
 (c) City Kansas City (d) Street No. Memorah Hosp. St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 570 Martin Cohen
 (a) Residence, No. 3715 Forest St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF None

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 9, 1921

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
17 7 26

8. Trade, profession, or particular kind of work done, as a lawyer, bookkeeper, etc. School

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Fall River Mass.

FATHER 13. NAME Samuel Cohen
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Russia

MOTHER 15. MAIDEN NAME Elizabeth Levine
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Fall River Mass.

17. INFORMANT Louis Cohen
 (ADDRESS) 3715 Forest

18. BURIAL, CREMATION, OR REMOVAL PLACE Shelfield Cem. DATE 11-6-38

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. P. Louis Funeral Home
R. C. Meigs

20. FILED Nov. 6 1938 M. M. Crowne
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 5, 1938

22. I HEREBY CERTIFY, That I attended deceased from Oct 20, 1938 to Nov 5, 1938
 I last saw him alive on Nov 5, 1938 Death is said to have occurred on the date stated above, at 11:55 a.m.
 The principal cause of death and related causes of importance were as follows:
Subacute bacterial endocarditis with cerebral embolus

Date of onset About Sept 11/38

Other contributory causes of importance:

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
 If so, specify.....
 (Signed) A. Sopher, M. D.
 (Address) 1405 Bryant Bldg

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.

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.....

P. O. Address.....

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, above space should be left blank.