

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. _____

4256

Registration District No. 791

Primary Registration District No. _____

Registrar's No. _____

1086

1. PLACE OF DEATH:

- (a) County _____
- (b) City or town St. Louis, Mo. 3
- (c) Name of hospital or institution:
Enroute to Jewish Hospital
(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)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County _____
- (c) City or town St. Louis 5
(If outside city or town limits, write "RURAL")
- (d) Street No. 5796 Westminster
(If rural, give location)
- (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb 1 day _____
year 1940 hour 4 minute 30 P M.
21. I hereby certify that I attended the deceased from Aug
1936, to Feb 2 1940,
that I last saw her alive on Dec 28 1939
and that death occurred on the date and hour stated above.
- Immediate cause of death Hyphertension Duration _____

- Due to Bleeding pneumonia
- Due to _____
- Other conditions _____
(Include pregnancy within 3 months of death)
- Major findings:
Of operations _____
- Of autopsy _____
- PHYSICIAN _____
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME Ida Cohn

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Sam Cohn 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 9 1870
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 8 22 _____ hr. _____ min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Garage Operator

11. Industry or business Garage

12. Name Isidor Alsberg

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name UNKNOWN
(City, town, or county) (State or foreign country)

15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature J. W. Cohn

- (b) Address 275 N. Union Blvd.

17. (a) Burial (b) Date thereof Feb. 4 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation Mt. Sinai Cemetery

18. (a) Signature of funeral director Berman Rindskopf

- (b) Address 5216 Delmar

19. (a) FEB 2 1940
(Date received local registrar) (Signature)

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

- (a) Accident, suicide, or homicide (specify) None
- (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 No injury

23. Signature John C. Brown (M. D. or other) _____
Address 4218 Washington Ave Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

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

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 me

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

Signed Chas. W. Cooper

Licensed Embalmer No. 3830

P. O. Address 5216 Delmar

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.