

No. 2
11-10-39
1-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **16858**
Registrar's No. **4336**

Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 5141a Cates
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) 15 yrs

3. (a) PRINT FULL NAME Hyman Cohen **570**

3. (b) If veteran, name war no 3. (c) Social Security No. 496-03-0562

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Rose Sapot Cohen 6. (c) Age of husband or wife if alive (unk) years
7. Birth date of deceased Feb. 10, 1889
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
51 3 4 hr. min.

9. Birthplace Wilno Poland Russia
(City, town, or county) (State or foreign country)

10. Usual occupation Cutter

11. Industry or business Ladies wear

12. Name Berel Cohen

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

14. Maiden name Rasha Bailey

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

16. (a) Informant George Cohen

(b) Address 5141a Cates

17. (a) burial (b) Date thereof 5/15/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chesed Shel Emeth

18. (a) Signature of funeral director H. B. Berger
(b) Address 4715 W. C. Pherson

19. (a) MAY 15 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis **12**
(If outside city or town limits, write "RURAL")
(d) Street No. 5141a Cates
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 50 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14
year 1940 hour 3:30 am minute _____ M.

21. I hereby certify that I attended the deceased from Sept. 27, 1937 to May 14, 1940,
that I last saw him alive on May 14, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death Spasm of anterior coronary artery Duration _____

Due to Coronary sclerosis **17** Myocardial infarction

Due to _____

Other conditions _____
(Exclude pregnancy within 9 months of death)

Major findings:
Of operations _____
Of autopsy _____

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 4-14-40

(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 _____

23. Signature R. M. S. [Signature] (M. D. or other) _____

Address 601 No. Grand Date signed 4/14/40

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

MOTHER FATHER

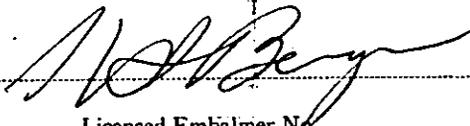
STATEMENT BY LICENSED EMBALMER

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.