

FILED SEP 25 1940

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

27222

Do not use this space.

## 1. PLACE OF DEATH

(a) County ..... Registration District No. 791  
 (b) Township ..... Primary Registration District No. 1003 Registered No. 7118  
 (c) City St Louis (d) Street No. James Hospital 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

(a) Residence, No. 5037 Enright St. 12 (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) married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mollie Cohen  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) DEC-15-1878  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 61 10 7  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Merchant  
 9. Industry or business in which work was done, as saw mill, bank, etc. Country  
 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) Russia  
 FATHER 13. NAME Sara Leah Cohen  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Russia  
 MOTHER 15. MAIDEN NAME Hinda Feldman  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Russia  
 17. INFORMANT (ADDRESS) Sarah Kransberg  
9900 Olive St Road  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Crest Shelburne DATE Aug 23 1940  
 19. FUNERAL DIRECTOR (ADDRESS) Odenhandler  
4469 Washington  
 20. FILED AUG 23 1940 J. B. Budick Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-22 1940  
 22. I HEREBY CERTIFY, That I attended deceased from 7-12 1940, to 8-22 1940  
 I last saw him alive on 8-22 1940 Death is said to have occurred on the date stated above, at 6:50 P.M.  
 The principal cause of death and related causes of importance were as follows:  
Pericerephritis  
not Calculous  
 Date of onset ?  
1330  
 Other contributory causes of importance:  
Reaction secondary to Blood transfusion  
 Name of operation none Date of .....  
 What test confirmed diagnosis? none 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? No  
 If so, specify  
 (Signed) Benj. F. May, M. D.  
 (Address) 589 W. Grant

STATEMENT BY LICENSED EMBALMER

I, W B Benkhandler

Licensed Embalmer No. 3669

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

myself

L. E.

No. \_\_\_\_\_ or by \_\_\_\_\_  
working under my personal supervision.

Registered Apprentice No. \_\_\_\_\_

Signed W B Benkhandler

Licensed Embalmer No. 3669

**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.)**