

Registration District No. **791** Primary Registration District No. _____
FILED DEC 11 1940

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: **Jewish Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **10 days**
(Specify whether
In this community **1 51 yrs.**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **5707 McPherson Ave.**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? **51 yrs.** years.

3. (a) PRINT FULL NAME **Arthur Kohn**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Belle Kohn** 6. (c) Age of husband or wife if alive **52 yrs.** years

7. Birth date of deceased **Unknown**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
About 58 hr. min.

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

10. Usual occupation **Retired Merchant**

11. Industry or business **General**

12. Name **Unknown**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Mrs. Arthur Kohn**

(b) Address **5707 Mc Pherson Ave.**

17. (a) **Burial** (b) Date thereof **11-7-1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Chesed Shel Emeth Cem.**

18. (a) Signature of funeral director **Herman Rindskopf**

(b) Address **5216 Delmar Blvd.**

19. **NOV 7 1940** (b) **J. H. ...**
(Date received from registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **5** year **1940** hour **8** minute **47** M.

21. I hereby certify that I attended the deceased from **March 1940** to **Nov. 5 1940**
and that death occurred on the date and hour stated above.

Immediate cause of death **Subarachnoid hemorrhage** Duration **60 hours**

Due to **Arterio sclerosis** Years.

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy _____

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

(a) Accident, suicide, or homicide (specify) _____

(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 _____

23. Signature **Joseph ...** (M. D. or other) **and**

Address **5500 Olive** Date signed **11/6/40**

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

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 *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, fact should be so stated above.