

No. 2
4-13-40
-17-39
I X23159

JAN 8 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

41395
State File No. 4788
Registrar's No.

Registration District No. 399

Primary Registration District No. 1002

Real to Bldg.
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: 2821 E 37th St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Unknown (Specify whether
In this community Unknown years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2821 E 37th St
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Wolf J. Cohn (Wolf J. Cohn)
(b) If veteran, name war No
(c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec day 17
year 1940 hour 8 minute A M.

4. Sex Male 5. Color or race Wh.
6. (a) Single, widowed, married, divorced, Married
6. (b) Name of husband or wife Mary
6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased Not known
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct 1st
1940, to Dec 17th, 1940
that I last saw him alive on Dec 14th, 1940
and that death occurred on the date and hour stated above.

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

Immediate cause of death Chronic myocarditis
Duration _____

9. Birthplace Russia
(City, town, or county) (State or foreign country)
10. Usual occupation Retired

Due to gbc
Due to _____

MOTHER FATHER
11. Industry or business 7
12. Name Rueben Cohn
13. Birthplace Russia
(City, town, or county) (State or foreign country)
14. Maiden name Rose
15. Birthplace Russia
(City, town, or county) (State or foreign country)

Other conditions malnutrition
(Include pregnancy within 3 months of death)
PHYSICIAN _____

16. (a) Informant Abraham Cohn
(b) Address K. C. Mo.
17. (a) Burial (b) Date thereof 12-18-40
(Burial, cremation, or removal) (Month) (Day) (Year)

Major findings:
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

(c) Place: burial or cremation Sheffield Cem
18. (a) Signature of funeral director J. P. Louis Funeral Home
(b) Address K. C. Mo.
19. (a) 12-17-40 (b) M. M. Browne
(Date received local registrar) (Registrar's signature)

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? _____

(Specify type of place) (e) Means of injury _____
23. Signature Joseph Galton (M. D. or other) M.D.
Address 1319 Realto Bldg Date signed 12-17-40

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..... *A. G. Lewis*

Licensed Embalmer No. *3110*

P. O. Address..... *K.C., Mo.*

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.