

FILED JUL 17 1942

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 2649

1. PLACE OF DEATH:

(a) County JACKSON
(b) City or town KANSAS CITY, MO.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3124 WAYNE AVE. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 45 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County JACKSON
(c) City or town KANSAS CITY 48
(If outside city or town limits, write "RURAL")
(d) Street No. 3124 WAYNE AVE 3
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 3

3. (a) PRINT FULL NAME SAMUEL H. COHN

3. (b) If veteran, name war No. 3. (c) Social Security No. No.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife CARRIE COHN 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased NOT KNOWN
(Month) (Day) (Year)

8. AGE: Years 66 Months Days If less than one day hr. min.

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

10. Usual occupation Retired

11. Industry or business

12. Name NOT KNOWN 9

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

14. Maiden name NOT KNOWN 9

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

16. (a) Informant FRANK COHN
(b) Address 3124 WAYNE

17. (a) BURIAL (b) Date thereof JULY 10 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation SHEFFIELD CEM.

18. (a) Signature of funeral director J.P. LOUIS Funeral Home
(b) Address 3400 WOODLAND AVE.
(c) Date 7-11-42 (d) M. M. CROW
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 9
year 1942 hour 4 minute 0 M.

21. I hereby certify that I attended the deceased from May 1 -
1942 to July 9 1942
that I last saw him alive on July 8 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction

Due to Valvular Heart Disease

Due to Diabetes 61 15 yr

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations
Of autopsy ---

Duration
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 _____

(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?

23. Signature Paula Jackson (M. D. or other) MD
Address 1163 E. Crown Date signed 7-9-42

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

341

CARL
A. JACKSON

11/03
KANSAS
M. J. JACKSON

11/03
KANSAS
M. J. JACKSON

11/03
KANSAS
M. J. JACKSON

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, fact should be so stated above.