

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registrar's No. 3370

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
General Hospital #2 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4/21-7/31/43  
(Specify whether  
In this community 50 Years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48  
(c) City or town Kansas City 8  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2711 Bell  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME SHERMAN COHN

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or Race Negro 6. (a) Single, widowed, married, divorced Widower  
6. (b) Name of husband or wife Sarah Ann Cohn 6. (c) Age of husband or wife if alive years  
7. Birth date of deceased October 25 1867  
(Month) (Day) (Year)

8. AGE: Years 75 7/2 Months 9 Days 6 If less than one day hr. min.

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

10. Usual occupation Unemployed

11. Industry or business Unknown

MOTHER { 12. Name Unknown  
13. Birthplace Unk. 9  
(City, town, or county) (State or foreign country)  
14. Maiden name Ann  
15. Birthplace Unk. 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk

(b) Address General Hospital #2

17. (a) burial (b) Date thereof 8/4/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation Highlands

18. (a) Signature of funeral director Waters Bros

(b) Address 1729 Lydia

19. (a) 8-4-43 (b) J. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31  
year 1943 hour 9:45 minute A M.

21. I hereby certify that I attended the deceased from April 21, 1943, to July 31, 1943,  
that I last saw him alive on July 31, 1943,  
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Broncho-Pneumonia Duration \_\_\_\_\_

Due to Cerebral Thrombosis 109

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy Same as above

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) Means of injury 0

23. Signature J. E. Brown (M. D. or other) \_\_\_\_\_

Address New Dep. 1 2600 E. 22nd Date signed 8-3-43

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.....

*J. Manlove*

Licensed Embalmer No. *3994*

P. O. Address. *25839 Highland*

**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.**