

S. No. 2  
DM-5-43  
v. 5-17-39  
I X36671

32152

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 9449

Registration District No. 15 848

Primary Registration District No. 1003

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

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:  
1438 E. Grand  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community 45 years (Specify whether 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. 1438 E. Grand  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Frieda Cohen  
(b) If veteran, name war no  
(c) Social Security No. NO

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month November 7  
year 1944 hour 6 minute 15 AM  
21. I hereby certify that I attended the deceased from Sept 1  
1944 to November 7, 44  
that I last saw her alive on November 1, 1944  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race white  
6. (a) Single, widowed, married, divorced widow  
(b) Name of husband or wife William Cohen  
(c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased (unk.)  
(Month) (Day) (Year)

Immediate cause of death Coronary occlusion Duration \_\_\_\_\_  
Due to arteriosclerosis \_\_\_\_\_ years  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) GH  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
ab. 77 hr. \_\_\_\_\_ min.

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

9. Birthplace Kiev USSR. 6  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Hirsch Privalsky  
13. Birthplace USSR. 6  
(City, town, or county) (State or foreign country)  
14. Maiden name Sophie Gochfeld  
15. Birthplace USSR. 6  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Sylvia Flegel  
(b) Address 5421 Wabada

17. (a) Burial (b) Date thereof 11/8/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chesed Shel Emeth

18. (a) Signature of funeral director Berger Memorial  
(b) Address 4715 Mc. Pherson

19. (a) NOV 8 1944 J. F. Bredeek  
(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?  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature Phinbaum (M. D. or other) \_\_\_\_\_  
Address 7651 Grandel Sp Date signed 11/7/44

(Licensed Embalmer's Statement on Reverse Side)

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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.....

1597

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.**