. S. No. 2
0M—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 14 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25521

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7753

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 (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town University City
(If outside city or town limits, write "RURAL")
(d) Street No. 6425 Cates ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Unnamed Inft. Cohen

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex female

5. Color or race white

6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased September 2, 1945 (Month) (Day) (Year)

8. AGE: Years | Months | Days 1 | If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) 0 (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name David Cohen
13. Birthplace St. Louis (City, town, or county) 0 (State or foreign country)

MOTHER
14. Maiden name Estelle Smith
15. Birthplace St. Louis (City, town, or county) (State or foreign country)

16. (a) Informant D. Cohen
(b) Address 6425 Cates U. City

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 9/4/45 (Month) (Day) (Year)
(c) Place: burial or cremation Chesed Shel Emeth

18. (a) Signature of funeral director Berger Memorial
(b) Address 4715 McPherson ave.

19. (a) SEP 4 1945 (Date received local registrar) (b) J. F. Breuer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 3 year 1945 hour 5 minute P. M.

21. I hereby certify that I attended the deceased from Sept. 2, 1945 to Sept. 3, 1945 that I last saw her alive on Sept. 3, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Premature birth	
Atelectasis	24 hours
Due to Prematurity	
Due to 159	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy none

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Lawrence Jolson (M. D.)
Address Jewish Hospital Date signed 9/4/45

(Licensed Embalmer's Statement on Reverse Side)

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 .....

..... no embalming, 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.