

FILED FEB 11 1946

State File No.

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 90

1. PLACE OF DEATH

(a) County Buchanan
(b) City or town St. Joseph
(c) Name of hospital or institution: St. Joseph Hosp # 1
(d) Length of stay: In hospital or institution 38 yrs 0 mo 26 days
In this community 38 yrs 0 mo 26 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 11
(c) City or town Kansas City Mo 1
(d) Street No. 1119 Walnut 7
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME Michael B Cohn

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married: divorced Single
6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive years
7. Birth date of deceased not given

8. AGE: Years About 65 Months ? Days ? If less than one day hr. min.

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

10. Usual occupation Born Reeper

11. Industry or business

12. Name yet given
13. Birthplace Kansas (City, town, or county) (State or foreign country)
14. Maiden name not given
15. Birthplace Kansas (City, town, or county) (State or foreign country)

16. (a) Informant Joseph B Cohn
(b) Address

17. (a) Removal (burial, cremation, or removal) (b) Date thereof Jan 25 46
(c) Place: burial or cremation: Sheffield Cemetery K.C. Mo.

18. (a) Signature of funeral director: H D Piperman
(b) Address: 2738 Prospect St. K.C. Mo.

19. (a) Date received local registrar: Jan 23 1946 (b) Registrar's signature: [Signature]

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 24 year 1946 hour 1:40 minute 8 M.

21. I hereby certify that I attended the deceased from Jan 10 1946 to Jan 23 1946 that I last saw him alive on Jan 23 1946 and that death occurred on the date and hour stated above.

Immediate cause of death: Primary Anemia
Due to: Probable malignancy

Other conditions: (Include pregnancy within 3 months of death)

Major findings: Of operations: 73
Of autopsy:

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: [Signature] (M. D. or other) no. Date signed: [Signature]

Duration 2 yrs.
PHYSICIAN Underline the cause to which death should be charged statistically.

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

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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 *Frances Wall*

....., Registered Apprentice No. *2744-*
working under my personal supervision.

Signed *Joe H. Tigerman*

Licensed Embalmer No. *2744*

P. O. Address *2738 Prospect*

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.