

FILED FEB 20 1946
Registration District No. 318

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: Barnes Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 38 days
(Specify whether

In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 5000

(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 17

(d) Street No. 5215 Vernon Ave.
(If rural, give location) 9

(e) Citizen of foreign country?..... (Yes or No) 10

If yes, name country.....

3. (a) PRINT FULL NAME JAMUEL WILLIAM COHEN

3. (b) If veteran, name war.....

3. (c) Social Security No.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 9
year 46 hour 8 minute 15 P. M.

21. I hereby certify that I attended the deceased from JAN. 2, 1946, to FEB. 9, 1946;
that I last saw him alive on FEB. 9, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death
Bronchogenic carcinoma with metastases to pleura
Due to etc.

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy none performed

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Rose Klamon Cohen

6. (c) Age of husband or wife if alive 37 years

7. Birth date of deceased Dec. 17 1905
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>40</u>	<u>1</u>	<u>23</u>	hr. min.

Duration

Physician

Underline the cause to which death should be charged statistically.

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

10. Usual occupation Restaurateur

11. Industry or business.....

MOTHER FATHER { 12. Name Henry Cohen

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

14. Maiden name Bella Forman

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

16. (a) Informant Mrs. Samuel W. Cohen

(b) Address 5215 Vernon Ave.

17. (a) Burial (b) Date thereof 2-10-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olive Cemetery

18. (a) Signature of funeral director H. Rindskopf

(b) Address 5216 Delmar Blvd.

19. (a) FEB 10 1946 (b) J. F. Brudack
(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?
(Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature JR Bradley (M. D. or other).....
Address Barnes Hospital Date signed 2/9/46

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. C. Burgess

Licensed Embalmer No. *4029*

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.