

No. 2
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5-17-39
I X47070

FILED AUG 4 3 1947
Registration District No. **3187**

Primary Registration District No. **1003**

Registrar's No. **6935**

1. PLACE OF DEATH:

(a) County St. Louis

(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 12 weeks
(Specify whether years, months or days)

In this community 55 years

3. (a) PRINT FULL NAME ETHEL COHEN

3. (b) If veteran, name, war No

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Ephriam Cohen

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

7. Birth date of deceased: Unknown
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

About 78 hr. min.

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

10. Usual occupation: At Home

MOTHER FATHER

11. Industry or business:

12. Name: Israel Katz

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

14. Maiden name: Unknown

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

16. (a) Informant: A.P. Cohen

(b) Address: 5917 Washington Avenue

17. (a) Burial (b) Date thereof: 7/25/1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Beth Ham Hag

18. (a) Signature of funeral director: Berger Memorial

(b) Address: 4715 McPherson Avenue

19. (a) JUL 25 1947 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

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

(d) Street No. 5917 Washington
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 25
year 1947 hour 3 minute 56.9 M.

21. I hereby certify that I attended the deceased from Feb. 1944 to July 24 1947
that I last saw her alive on July 24 1947
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral hemorrhage Duration 2 mo.

Due to: Hypertension + arteriosclerosis 10 yrs

Due to _____

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

Major findings: _____

Of operations: _____

Of autopsy: _____

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature: Bennett L. Tausig (M. D. or other) MD

Address: 4500 Olive St. Date signed: July 25

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

2292-028

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.....

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.