S. No. 300
M—10-47
ev. 5-17-39
I 3906

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 37980

Registration District No. FILED DEC 2 1948 318

Primary Registration District No. 1003

Registrar's No. 10175

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

(d) Length of stay: In hospital or institution 7½ wks (Specify whether
In this community 36 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County

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

(d) Street No. 5212 Enrighty
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME ANNA COHEN

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex female

5. Color or race white

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

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

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

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

8. AGE: Years	Months	Days	If less than one day
ab 57			hr. min.

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

10. Usual occupation at home

11. Industry or business

FATHER
12. Name Rubin Shaul
13. Birthplace (City, town, or county) USSR (State or foreign country)

MOTHER
14. Maiden name Esther Unk,
15. Birthplace (City, town, or county) USSR (State or foreign country)

16. (a) Informant Mr. A. Cohen
(b) Address 5212 Engright

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/48 (Month) (Day) (Year)
(c) Place: burial or cremation Chesed Shel Emeth

18. (a) Signature of funeral director BERGER MEMORIAL
(b) Address 4715 McPherson

19. (a) (Date received local registrar) (b) J B Lander (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov 23 day
year 1948 hour 7 am minute M.

21. I hereby certify that I attended the deceased from Nov, 1948, to 11-23, 1948, that I last saw him alive on 11-23, 1948, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Metastatic carcinoma of breast	6 mo.
Due to	
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature H L Jaslin (M. D. or other) M.D.
Address 3905 Olive Date signed 11-23-48

(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.....

.....Registered Apprentice No.....,

working under my personal supervision.

Signed. Jens Ludvig

Licensed Embalmer No. 4229

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.