

FILED JUN 2 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 15634

BIRTH NO. _____		REG. DIST. NO. 137		PRIMARY REG. DIST. NO. 3623		Registrar's No. 135	
1. PLACE OF DEATH a. COUNTY <u>Henry</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Henry</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Clinton</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <u>Clinton Mo</u>		42	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1</u>				d. STREET ADDRESS (If rural, give location) <u>301 S Washington</u>			
3. NAME OF DECEASED (Type or Print) <u>GOTTIEB ARENSDORFF COHEN</u>		a. (First) <u>GOTTIEB</u> b. (Middle) <u>ARENSDORFF</u> c. (Last) <u>COHEN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>5-22-49</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>FEB 26 1875</u>	9. AGE (In years last birthday) <u>74</u>	10. MONTHS <u>3</u>	11. DAYS <u>22</u>	12. IF UNDER 1 YEAR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Salvage</u>		11. BIRTHPLACE (State or foreign country) <u>St Louis Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Samuel Bernard Cohen</u>		13b. MOTHER'S MAIDEN NAME <u>Amelia Sack</u>		14. NAME OF HUSBAND OR WIFE <u>Mabel Irene Cohen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mabel Irene Cohen</u> ADDRESS <u>Clinton Mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u>							
DUE TO (c) _____							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				4201			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>5/22</u> , 19 <u>49</u> , to <u>Dead on arrival</u> , 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>2:45 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Quaid N. [Signature]</u> (Degree or title) <u>2 DO</u>		23b. ADDRESS <u>105 E Ohio Clinton Mo</u>		23c. DATE SIGNED <u>May 24 1949</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>5/25/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Union Cem Sedalia Mo</u>		24d. LOCATION (City, town, or county) (State) _____	
DATE REC'D BY LOCAL REG. <u>5-25-49</u>		REGISTRAR'S SIGNATURE <u>Florence Adair</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J E Consolator</u> ADDRESS <u>Clinton Mo</u>			

**RECEIVED**

District Health Officer No. 7

District File Number 4-49-60

Date Filed 5-31-69

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

*J. E. Cornolui*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 1 P 9 1

P. O. Address Clinton, N.Y.

**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.