No. 300
10.48

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

FILED OCT 7 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31677

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8118

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ST. LOUIS
c. LENGTH OF STAY (in this place) /
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. JOHNS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE MO.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ST. LOUIS
d. STREET ADDRESS (If rural, give location) 3830 PARK AV.

3. NAME OF DECEASED (Type or Print)
a. (First) MAUDE
b. (Middle) Cohn
c. (Last)

4. DATE OF DEATH (Month) (Day) (Year) SEPT-18-1949

5. SEX FEMALE
6. COLOR OR RACE W
7. MARRIED, ~~NEVER MARRIED, WIDOWED, DIVORCED~~ (Specify) MARRIED
8. DATE OF BIRTH FEB. 4-1903
9. AGE (In years last birthday) 46 YRS. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER
10b. KIND OF BUSINESS OR INDUSTRY OWN
11. BIRTHPLACE (State or foreign country) SALEM MO.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME UNKNOWN STEELMAN
13b. MOTHER'S MAIDEN NAME DORA UNKNOWN.
14. NAME ~~OF HUSBAND OR~~ WIFE WILLIAM B. Cohn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME ADDRESS

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) Uremia — INTERVAL BETWEEN ONSET AND DEATH 5 DAYS

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) [illegible]

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

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) 131a

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 446X

22. *I hereby certify that I attended the deceased from* aug., 1946, *to* sept. 18, 1949, *that I last saw the deceased alive on* sept. 18, 1949, *and that death occurred at* 5:45 p m., *from the causes and on the date stated above.*

23a. SIGNATURE Lew Osh. (Degree or title) MD
23b. ADDRESS 4030 Chouteau ave.
23c. DATE SIGNED 9/19/49.

24a. BURIAL, ~~CREMATION, REMOVAL~~ (Specify) BURIAL
24b. DATE SEPT. 21-49
24c. NAME OF CEMETERY ~~OR CREMATORY~~ MT. Hope CEMETERY
24d. LOCATION (City, town, or county) ST. Louis CTY (State) Mo.

DATE REC'D BY LOCAL REG. SEP 20 1949
REGISTRAR'S SIGNATURE J B Lacata
25. FUNERAL DIRECTOR'S SIGNATURE E. J. Schnur ADDRESS 3125 Lafayette

(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.....

.....,

working under my personal supervision.

Student Embalmer/No.....

Signed Jos B Vollmer

Signed.....
Student Embalmer

Licensed Embalmer No. 4014

P. O. Address 3135 Lafayette

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.