

# STANDARD CERTIFICATE OF DEATH

36258

State File No. ....

FILED NOV 12 1952

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BIRTH NO. ....		REG. DIST. NO. ....		PRIMARY REG. DIST. NO. ....		Registrar's No. ....	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN		c. LENGTH OF STAY (in this place) township)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN		2259	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				d. STREET ADDRESS (If rural, give location)			
JEWISH HOSPITAL				25 1408 BIDDLE			
3. NAME OF DECEASED (Type or Print)		a. (First)		b. (Middle)		c. (Last)	
LOUIS						COHEN	
4. DATE OF DEATH		(Month)		(Day)		(Year)	
OCT 15 1952							
5. SEX		6. COLOR OR RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH	
MALE		white		married		19. AGE (In years last birthday)	
						26 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			
Presser		Mant.		Romania 6			
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE	
USA		Michel Cohen		Betty (unk)		Rose	
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			
No		unk		Ther Shuly Segel 7335 Helman			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION					
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ANOXIA					
		INTERVAL BETWEEN ONSET AND DEATH 3 days					
		ANTECEDENT CAUSES					
		DUE TO (b) BRONCHOPNEUMONIA					
		DUE TO (c) CHRONIC BRONCHITIS-BRONCHIECTASIS 720yrs					
		II. OTHER SIGNIFICANT CONDITIONS					
		SUPRAPUBIC PROSTATECTOMY					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
10-9-52		BENIGN PROSTATIC HYPERTROPY					
20. AUTOPSY?		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)	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						ST. LOUIS MO.	
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			
				526X			
22. I hereby certify that I attended the deceased from Sept 14, 1952, to Oct. 15, 1952, that I last saw the deceased alive on Oct. 15, 1952 and that death occurred at 11 P.M., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title)				23b. ADDRESS		23c. DATE SIGNED	
Kenneth D. Serbes M.D.				JEWISH HOSP., ST. LOUIS, Mo.		10/16/52	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)	
Burial		10/19/52		Crisa Shulman		University City Mo	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS					
OCT 16 1952		J. Carl Smith, M.D. 8715 Madison					

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

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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.

Signed.....  
Student Embalmer

Signed *Quinn J. Quindus*.....  
Student Embalmer No.....  
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.