

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26224

FILED JUL 31 1953

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6821

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> <u>2059</u>	
c. LENGTH OF STAY (In this place) <u>5 wks</u>		d. STREET ADDRESS (If rural, give location) <u>5846 Etzel</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Jewish Hosp.</u>		d. STREET ADDRESS <u>5846 Etzel</u>	

3. NAME OF DECEASED a. (First) <u>Bertha</u> b. (Middle) <u>11</u> c. (Last) <u>Cohen</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 9 1953</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>(unknown)</u>	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>USSR</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

13a. FATHER'S NAME <u>Reuben Shapiro</u>	13b. MOTHER'S MAIDEN NAME <u>(unknown)</u>	14. NAME OF HUSBAND OR WIFE <u>Benjamin Cohen</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Ben Cohen</u>	ADDRESS <u>5846 Etzel Ave</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u>
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Uremia</u>		DUE TO (b) <u>Chronic nephritis</u>		<u>years</u>
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c)		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 <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) <u>592 X</u>
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 9/16, 1953 to 7/9, 1953, that I last saw the deceased alive on 7/9, 1953, and that death occurred at 12:45 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Jos. M. Orenstein, M.D.</u>	23b. ADDRESS <u>4500 Olive St.</u>	23c. DATE SIGNED <u>7/10/53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	24b. DATE <u>7/12/53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Chevre Kadisha</u>	24d. LOCATION (City, town, or county) (State) <u>Univ. City Mo.</u>
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DATE REC'D BY LOCAL REG. <u>JUL 10 1953</u>	REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Berger Memorial</u>	ADDRESS <u>1715 McPherson</u>
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WRITE PLAINLY - USING UNFADING INK

**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.

Student .....  
Student Embalmer

Signed

\_\_\_\_\_

Licensed Embalmer No. 4239

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.