

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

State File No. **13557**

No. 300  
10.48  
FILED MAY 9 1955

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3400**

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS</b>		c. CITY OR TOWN <b>Clayton</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>The Jewish Hosp. of St. Louis</b>		e. STREET ADDRESS (If rural, give location) <b>7516 Parkdale Dr.</b>	

3. NAME OF DECEASED (Type or Print) <b>ABRAHAM KOHANE</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>April 15, 1955</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Jan. 26, 1899</b>		9. AGE (In years last birthday) <b>56</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Jewelry</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Canada</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>

13a. FATHER'S NAME <b>Isaac Kohane</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah Eichorn</b>		14. NAME OF HUSBAND OR WIFE <b>Florence Kohane</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. F. Kohane</b> ADDRESS <b>7516 Parkdale Dr.</b>	

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, ashenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>ACUTE HEMORRAGIC PANCREATITIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 Days</b>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>GASTRECTOMY for DUODENAL ULCER</b>		<b>5 Days</b>	
		DUE TO (c) <b>NONE</b>			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <b>4/9/55</b>		19b. MAJOR FINDINGS OF OPERATION <b>4/9-55 - DUODENAL ULCER; 4/14/55 - HEMORRAGIC PANCREATITIS</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR <b>5410</b>	

22. I hereby certify that I attended the deceased from **4/2/55**, 19**55**, to **4/15/55**, 19**55**, that I last saw the deceased alive on **4/15/55**, 19**55**, and that death occurred at **12:05 pm.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Marcelo A. Ferreira, M.D.</b> (Degree or title)		23b. ADDRESS <b>216 S. Kings Highway St. Louis (10)</b>		23c. DATE SIGNED <b>4/15/55</b>	
24a. BURIAL, CREMATION REMOVAL (Specify) <b>REMOVAL</b>		24b. DATE <b>4-17-1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>MT. SINAI CEM.</b>	
		24d. LOCATION (City, town, or county) (State) <b>ST. LOUIS COUNTY - MO.</b>			

DATE REC'D BY LOCAL REG. <b>APR 16 1955</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith MD</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>HERMAN RINDSKOPF INC.</b> ADDRESS <b>5216 DELMAR</b>	
---	--	---	--	--	--

(Licensed Embalmer's Statement on Reverse Side)

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

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.....  
Signature of Student Embalmer

Signed.....  
*John Ketter*

Licensed Embalmer No. 388

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.