

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44454

FILED DEC 31 1956

State File No. 3074

REG. DIST. NO. 333

PRIMARY REG. DIST. NO. 3074

Registrar's No. 195

BIRTH NO. _____		REG. DIST. NO. 333		PRIMARY REG. DIST. NO. 3074		Registrar's No. 195	
1. PLACE OF DEATH a. COUNTY Scott				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Scott			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sikeston		c. LENGTH OF STAY (in this place) Life		c. CITY OR TOWN Sikeston		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Delta Community Hospital				e. STREET ADDRESS (If rural, give location) 207 Trotter St. 10030			
3. NAME OF DECEASED (Type or Print)		a. (First) James		b. (Middle) Henry		c. (Last) Cohen	
4. DATE OF DEATH		(Month) 12		(Day) 12		(Year) 1956	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 1-10-1880	
9. AGE (In years last birthday) 76		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 4 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (City and State or Foreign Country) Jonesboro, Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME William Cohen		13b. MOTHER'S MAIDEN NAME Irene		14. NAME OF HUSBAND OR WIFE Florence Cooper			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 0		16. SOCIAL SECURITY NO. 0		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Florence Cohen, Sikeston, Mo.			
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure				INTERVAL BETWEEN ONSET AND DEATH 4 hrs	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Cardiovascular Disease unknown					
		DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 1. Uremia 2. Hemias Inguinal Indirect R.				4 hrs unknown	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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) 443x			
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?			
22. I hereby certify that I attended the deceased from Nov 19, 1956 , to 12-12, 1956 , that I last saw the deceased alive on 12-12, 1956 , and that death occurred at 10:48 P. m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Andrew B. Smith M.D.				23b. ADDRESS Sikeston, Mo.		23c. DATE SIGNED 12-13-56	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 12-15-1956		24c. NAME OF CEMETERY OR CREMATORY Matthews Cem.		24d. LOCATION (City, town, or county) (State) Matthews, Mo.	
DATE REC'D BY LOCAL REG. 12-17-56		REGISTRAR'S SIGNATURE Mrs. Olla Hunt		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Funeral Home, Sikeston			

(Licensed Embalmer's Statement on Reverse Side)

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

429
0

2nd

DEC 24 1956

DATE RECEIVED

SCOTT CO. HEALTH DEPT.

CO. FILE No. 1256-271

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 *J.E. McMillan*

Licensed Embalmer No. 4691

P. O. Address Paulina, Mo.

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.