

health, Welfare Public Service
 000
 -56
 Director, coroner, etc. must use only standard nomenclature in item 10. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

19498
 STATE FILE NUMBER

FILED MAY 20 1957

Registration District No. 317 Primary Registration District No. 531 Registrar's No. 1226

1. PLACE OF DEATH a. COUNTY St. Louis			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN University City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN University City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 8700 Washington		Length of stay in lbs 7 yrs.	d. STREET ADDRESS (If outside, give location) 8701 Washington		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) MAX COHEN			4. DATE OF DEATH May 12, 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 1, 1900	9. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY Accounting	11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Frank Cohen			14. MOTHER'S MAIDEN NAME Sophie Pearl		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 497-07-6608	17. INFORMANT Address Mrs. Max Cohen 8701 Washington		
18. CAUSE OF DEATH [Enter only one cause per line for (a); (b); and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION					INTERVAL BETWEEN ONSET AND DEATH 10 YRS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) ARTERIO SCLEROTIC AT OIS			
		DUE TO (c) HYPER TENSION			
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4200					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 1/18/56 to 5/12/57 and last saw ^{her} / _{him} alive on 5/9/57 Death occurred at 6 A m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Maxwell C. Levin			22b. ADDRESS 100 N. Euclid		22c. DATE SIGNED 5/13/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/13/57	23c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth		23d. LOCATION (City, town, or county) (State) University City, Mo.	
24. FUNERAL DIRECTOR ADDRESS Berger Memorial 4715 McPherson		25. DATE RECD. BY LOCAL REG. 5-13-57	26. REGISTRAR'S SIGNATURE Hubert B. Donohue		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

St. Louis Mo. University City Washington 7 yrs. 1900
 St. Louis Mo. University City Washington 7 yrs. 1900
 Max Cohen
 Male White
 Accountant
 Frank Cohen
 St. Louis, Mo. Accounting
 Sophie Pearl
 Mrs. Max Cohen 3701 Washington
 No. 107-07-6608

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by Student Embalmer No.

working under my personal supervision..

Student
Signature of Student Embalmer

Signed *Sawyer J. Birn*
Licensed Embalmer No. *39*

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.

Reverend Memorial Mrs. Cohen