

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2771

FILED FEB 14 1958

Registration District No.

318

Primary Registration District No.

1003

STATE FILE NUMBER

Registrar's No. 566

300
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

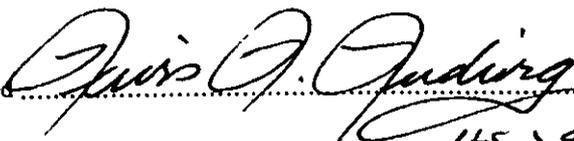
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>University City</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jewish Hosp.</u>		Length of stay in 1b <u>2 hrs.</u>		d. STREET ADDRESS (If outside, give location) <u>8345 Delcrest</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ISAAC</u> Middle Last <u>COHEN</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>15</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 14 1872</u>		9. AGE (In years last birthday) <u>85</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mens Furn.</u>		11. BIRTHPLACE (City and state or country) <u>USSR</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Sam Cohen</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Shank</u>			14. NAME OF HUSBAND OR WIFE <u>Eva</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Bialick 7133 Dartmouth</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C-V Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>23 yrs.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>coronary sclerosis.</u>						<u>5 yrs.</u>	
DUE TO (c) <u>420.1</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Stokes-Adams Syndrome.</u>						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 <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 <u>Apr. 1935</u> to <u>Jan 15, 1958</u> and last saw ^{her} him alive on <u>Jan 15, 1958</u> Death occurring <u>4:30 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Mrs. Cliff W.D.</u>				22b. ADDRESS <u>601 Humboldt Bldg</u>		22c. DATE SIGNED <u>1/16/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Rem.</u>		23b. DATE <u>1/17/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chesed Shel Emeth</u>		23d. LOCATION (City, town, or county) (State) <u>University City, Mo.</u>		
24. FUNERAL DIRECTOR <u>Berger Memorial 4715 McPherson</u>				25. DATE RECD. BY LOCAL REG. <u>JAN 16 '58</u>		26. REGISTRAR'S SIGNATURE <u>Paul Smith MD</u>	

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 
Licensed Embalmer No. 4529
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.