

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-023203

STATE FILE NUMBER

FILED JUL 1 1958 Registration District No.

318 Primary Registration District No. 1003

Registar's No. 6236

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 0/ 1814 Franklin		Length of stay in lb 1 yr	d. STREET ADDRESS (If outside, give location) 2219 1814 Franklin
3. NAME OF DECEASED (Type or print) First FRANK Middle Last COHEN		4. DATE OF DEATH Month June 17 Day 1958 Year	
5. SEX male 0	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> 0 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant retired		10b. KIND OF BUSINESS OR INDUSTRY Fruit	9. AGE (In years at birthday) 83 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and state or country) USSR 6		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Wm Cohen		13b. MOTHER'S MAIDEN NAME Frieda Prevulsky	
14. NAME OF HUSBAND OR WIFE None		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give No dates of service)	
16. SOCIAL SECURITY NO. None		17. INFORMANT Sol Cohen 1734 Washington Ave	
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>Cirrhosis of Liver</u> DUE TO (b) <u>Arterio Sclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 581.0	
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 _____ to _____ and last saw her alive on _____ Death occurred at _____ m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Joseph M. Quinn</i>		22b. ADDRESS 1300 Clark	
22c. DATE SIGNED 6/19/58			
23a. BURIAL, CREMATION, REMOVAL, (Specify) removal		23b. DATE 6/20/58	
23c. NAME OF CEMETERY OR CREMATORY Cheshed Shel Emeth		23d. LOCATION (City, town, or county) (State) University City, Mo.	
24. FUNERAL DIRECTOR Berger Memorial 4715 McPherson		25. DATE RECD. BY LOCAL REG. JUN 19 58	
26. REGISTRAR'S SIGNATURE <i>Carl Smith</i> MO			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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. 3988 .....

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.