

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014979

State File No. _____

2 2890

FILED MAY 1 1959

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mississippi</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>St. Louis, Mo.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Biloxi,</u>	
c. LENGTH OF STAY (In this place) <u>10/10/56</u>		d. STREET ADDRESS (If rural, give location) <u>2106 Wilkes</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Masonic Home of Missouri</u>			

3. NAME OF DECEASED a. (First) <u>Bertha Cohen</u> b. (Middle) <u>Frensdorf</u> c. (Last) _____			4. DATE OF DEATH (Month) <u>3</u> (Day) <u>20</u> (Year) <u>1959</u>		
--	--	--	---	--	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>2/2/1872</u>	9. AGE (In years last birthday) <u>87</u>	10. UNDER 1 YEAR Months _____ Days _____	11. UNDER 10 HRS. Hours _____ Min. _____
----------------------	-------------------------------	---	----------------------------------	---	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>West Meriden, Conn</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	--	--	--

13a. FATHER'S NAME <u>Morris Cohen</u>	13b. MOTHER'S MAIDEN NAME <u>Rachel Cohen</u>	14. NAME OF HUSBAND OR WIFE <u>Nathan Frensdorf</u>
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Masonic Home of Missouri, St. Louis, Mo.</u>	ADDRESS _____
--	-------------------------------------	---	---------------

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, asthma, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CEREBRAL HEMORRHAGE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>ONE DAY</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>HYPERTENSION</u>		
	DUE TO (c) <u>331x</u>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>CEREBRAL HEMORRHAGE WITH LEFT HEMIPLEGIA</u>		<u>15 MONTHS</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
------------------------	----------------------------------	--

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)	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 10-10-1956, to 3-20-1959, that I last saw the deceased alive on 3-20-1959, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Robert A. Hall</u>	(Degree or title) <u>M.D.</u>	23b. ADDRESS <u>5351 Delmar Blvd, St. Louis, Mo.</u>	23c. DATE SIGNED <u>3-21-59</u>
--------------------------------------	-------------------------------	--	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>3/23/59</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Sinai Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>
--	--------------------------	--	--

DATE REC'D BY LOCAL OFF. <u>MAR 23 59</u>	REGISTRAR'S SIGNATURE <u>Joan Smith, M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Herman Rindskopf, Inc.</u>	ADDRESS <u>5216 Delmar</u>
---	---	--	----------------------------

M. G. B. (Licensed Embalmer's Statement on Reverse Side)

WHILE FLAINLI—USING 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
Student Embalmer

Signed _____

John Ketter

Licensed Embalmer No. *3880*

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 this body is not embalmed, fact should be so stated above.