

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 28 1959

59-037495

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 9624**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE M^o b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 40 yrs.	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Orthodox Old Folks Home		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 438 E. Grand Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First JAKE (AKA JACOB) Middle COHEN Last COHEN			4. DATE OF DEATH Month Oct. Day 20 Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11/20/89	9. AGE (last birthday) 69	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe repair		10b. KIND OF BUSINESS OR INDUSTRY Retail Shop	11. BIRTHPLACE (City and state or country) Russia		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Mackid Cohen		13b. MOTHER'S MAIDEN NAME Unk.		14. NAME OF HUSBAND OR WIFE Unk	
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. None		17. INFORMANT Address S. Chait 6041 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) Cerebral Vascular Accident = Right Hemiparesis		INTERVAL BETWEEN ONSET AND DEATH 1 day
DUE TO (b)		
DUE TO (c) Arteriosclerosis, Generalized		Yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pulmonary Fibrosis - Emphysema 331x		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
---	--	--	--

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 _____ a.m. _____ p.m.	Month, Day, Year _____		

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 **1958** to **10/20/59** and last saw him alive on **10/19/59**.
Death occurred at **12:10 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Ray Greenbaum MD (Degree or title)	22b. ADDRESS 4652 Maryland	22c. DATE SIGNED 10/20/59
---	--------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Rem.	23b. DATE 10/21/59	23c. NAME OF CEMETERY OR CREMATORY Chevra Kadisha	23d. LOCATION (City, town, or county) University City, Mo.
--	------------------------------	---	--

24. FUNERAL DIRECTOR Berger Memorial 4715 McPherson ADDRESS	25. DATE RECD. BY LOCAL REG. OCT 20 59	26. REGISTRAR'S SIGNATURE Neal Smith, M.D.
---	--	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

m 815

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Quir J. Gaudery
Licensed Embalmer No. 4229

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.