

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003053

FILED VS JAN 19 1960

Registration District No. 316 Primary Registration District No. \_\_\_\_\_ Registrar's No. 15 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>St. Francois</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE <b>Missouri</b> b. COUNTY <b>City of St. Louis</b> )	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Francois Township</b>		Length of stay in 1b <b>25 Yrs., 9M; 18 days</b>	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital No. 4</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5795 Westminster</b>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <b>ADDIE</b> Middle _____ Last <b>COHN</b>			4. DATE OF DEATH Month <b>January</b> Day <b>10</b> , Year <b>1960</b>	
---	--	--	---	--

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 12, 1871</b>	9. AGE (last birthday) <b>88</b>	IF UNDER 1 YEAR Months <b>1</b> Days _____	IF UNDER 24 HR Hours _____ Min. _____
-------------------------	----------------------------------	---	--	-------------------------------------	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Owensboro, Kentucky</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
---	-----------------------------------	--	--

13a. FATHER'S NAME <b>Max Cohn</b>	13b. MOTHER'S MAIDEN NAME <b>Rebecca Wurtzburg</b>	14. NAME OF HUSBAND OR WIFE <b>Simon Jacobson</b>
---------------------------------------	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Records, State Hospital No. 4, Farmington, Mo.</b>	Address
---	---	--	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<b>Coronary Occlusion - - - - - instantaneous.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Coronary Sclerosis - - - - -</b>	<b>Unknown.</b>
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Psychosis with cerebral arteriosclerosis.</b>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 _____ 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 Jan. 23, 1959 to Jan. 10, 1960 and last saw her/him alive on Jan. 10, 1960  
Death occurred at 5:45 P. M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>John A. Brennan, M.D.</i> (Degree or title)	22b. ADDRESS <b>State Hospital No. 4 Farmington, Missouri</b>	22c. DATE SIGNED <b>1-11-60</b>
--	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Jan. 12, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Adath Israel Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Owensboro, Kentucky</b>
--	-----------------------------------	--	---

24. FUNERAL DIRECTOR <b>Glen Mortuary, Owensboro, Kentucky.</b>	25. DATE RECD. BY LOCAL REG. <b>Jan. 13, 1960</b>	26. REGISTRAR'S SIGNATURE <i>Ether Rudloff</i>
--	--	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1967 1 6 '67

**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 Paul H. Dugan

Licensed Embalmer No. 4120

P. O. Address Farmington

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.