

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. APP. 2 9 1960

=60-016698  
STATE FILE NUMBER

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar No. **3605**

INDEXED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in lb <b>10 days</b>	c. CITY OR TOWN <b>University City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jewish Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>7317 Amherst</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>WOLF</b> Middle <b>BEN</b> Last <b>COHEN</b>			4. DATE OF DEATH Month <b>March</b> Day <b>29</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1/15/1895</b>	9. AGE (last birthday) <b>65</b>	IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Decorator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Painting</b>		11. BIRTHPLACE (City and state or country) <b>Russia</b>		
13a. FATHER'S NAME <b>Samuel L. Cohen</b>		13b. MOTHER'S MAIDEN NAME <b>Mollie Kantor</b>		14. NAME OF HUSBAND OR WIFE <b>Rose</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>None</b>		17. INFORMANT <b>Rose Cohen 7317 Amherst Avenue</b>		

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>Uremia</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Polycystic kidneys</b>		
	DUE TO (c) <b>757.1</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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 **1941** to **March 29, 1960** and last saw him alive on **March 29, 1960**  
Death occurred at **11:30 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Julius Olson, M.D.</b>		22b. ADDRESS <b>607 N. Grand St. St. Louis</b>		22c. DATE SIGNED <b>3/30/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>3/31/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Chesed Shel Emeth</b>		23d. LOCATION (City, town, or county) <b>University City, Missouri</b>
24. FUNERAL DIRECTOR <b>Berger Memorial 4715 McPherson Avenue</b>		25. DATE RECD. BY LOCAL REG. <b>MAR 30 1960</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Lawrence J. Davis

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.