

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY <i>St. Louis</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Length of stay in 1b <i>3 wks</i>	c. CITY OR TOWN <i>University City</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Jewish Hospital</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>8665 Spoon Drive</i>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <i>ANNA COHEN</i>			4. DATE OF DEATH Month Day Year <i>December 14, 1960</i>		
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5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>1-22-1891</i>	9. AGE (last birthday) <i>69</i>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	11. BIRTHPLACE (City and state or country) <i>USSR</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>
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13a. FATHER'S NAME <i>David Schneider</i>	13b. MOTHER'S MAIDEN NAME <i>Naomi Fried</i>	14. NAME OF HUSBAND OR WIFE <i>David</i>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> or unknown) (If yes, give was dates of service)	16. SOCIAL SECURITY NO. <i>493-46-4855</i>	17. INFORMANT Address <i>Leo Frank 8665 Spoon Drive</i>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the stomach</i>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) <i>151X</i>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>metastases to liver + lung.</i>	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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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
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21. I attended the deceased from *7:00 November, 1959* to *present* and last saw her alive on *December 13, 1960*
 Death occurred at *7:00 a.m.* on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Michael M. Keel M.D.</i>	22b. ADDRESS <i>4652 Grand Lane</i>	22c. DATE SIGNED <i>12-14-60</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>12/15/1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>B'nai Amoona</i>	23d. LOCATION (City, town, or county) (State) <i>University City, Missouri</i>
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24. FUNERAL DIRECTOR ADDRESS <i>Berger Memorial 4715 McPherzon Avenue</i>	25. DATE RECD. BY LOCAL REG. <i>DEC 15 1960</i>	26. REGISTRAR'S SIGNATURE <i>Leon Smith, M.D.</i>
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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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Wm. J. Anderson

Licensed Embalmer No. 4229

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to
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.