

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-020280
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5426**

FILED JUN 7 1962

1. PLACE OF DEATH
a. COUNTY _____
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **St. Louis** Length of stay in 1b **10 mths.**
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **Jewish Hosp.** Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) **6318 Cabanne** Reside on Farm Yes No

3. NAME OF DECEASED First Middle Last 4. DATE OF DEATH Month Day Year
MINNIE COHEN **May 29, 1962**

5. SEX **Female** 6. COLOR OR RACE **White** 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH **Unk.** 9. AGE (last birthday) **ab. 77** IF UNDER 1 YEAR IF UNDER 24 HR
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife** 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (City and state or country) **Poland** 12. CITIZEN OF WHAT COUNTRY **USA**

13a. FATHER'S NAME **Unk. Blumberg** 13b. MOTHER'S MAIDEN NAME **Unk.** 14. NAME OF HUSBAND OR WIFE **Ben**

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 **Chas. Cohen 707 Eastgate**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Shock**
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) **Hypertensive, metastatic**
DUE TO (c) **180X**
INTERVAL BETWEEN ONSET AND DEATH **3 hrs.**
1 year

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.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 **7/1/61** to **5/29/62** and last saw him alive on **5/29/62**
Death occurred at **4:15 am** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **Oliver S. Werninger, M.D.** 22b. ADDRESS **8112 Delmar** 22c. DATE SIGNED **5/29/62**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Rem.** 23b. DATE **5/31/62** 23c. NAME OF CEMETERY OR CREMATORY **Beth Hamedrosh Hagodol** 23d. LOCATION (City, town, or county) (State) **Ladue, Mo.**

24. FUNERAL DIRECTOR ADDRESS **Berger Memorial 4715 Cherson** 25. DATE RECD. BY LOCAL REG. **MAY 31 1962** 26. REGISTRAR'S SIGNATURE **Roan Smith, M.D.**

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DATE AMENDED
INSTEAD OF
SHOULD READ
ITEM NO.

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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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 _____

Signature of Student Embalmer

Signed Lawrence J. Kerner

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.