

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

7727

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 1003
City St. Louis - Mo. (No. Jewish Hospital)

File No.....
Registered No. 2000
St..... Ward)

2. FULL NAME

Nathan Cohen
(a) Residence. No. 1400 Blackstone St., 6 Ward. 6
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 6 yrs. 6 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb-9-1925

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>6</u>			<u>6</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. School
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN). (STATE OR COUNTRY) St. Louis - Mo

PARENTS

10. NAME OF FATHER Ben Cohen
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Russia 23
12. MAIDEN NAME OF MOTHER Esther Sallman
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Russia

14. INFORMANT Ben Cohen
(Address) 1400 Blackstone

15. FILED 18 1931 May 11 1931 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/15 1931
17. I HEREBY CERTIFY, That I attended deceased from 2/14, 1931, to 2/15, 1931 that I last saw h. in alive on 2/15, 1931, and that death occurred, on the date stated above, at 9:45 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
7 Encephalitis Post-measles
783

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTACTED (duration) yrs. mos. ds.

IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH? DATE OF.....
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS Julius Elson, M. D.
(Signed) 2/15 1931 (Address) Jewish Hosp.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Cheresh Kehila DATE OF BURIAL Feb-16 1931

20. UNDERTAKER Oxshandler E.P. ADDRESS 4822 East...

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

