

REC'D APR 17 1939

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

9472
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson | Registration District No. 399
(b) Township Kaw | Primary Registration District No. 1002
(c) City KANSAS CITY | (d) Street No. MENORAH HOSPITAL Registered No. 1078
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME 50 LENA COHN
(a) Residence, No. 2205 E 38 St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX FEMALE
4. COLOR OR RACE WHITE
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ABRAHAM COHN
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) MARCH 27 1899
7. AGE YEARS 40 MONTHS 11 DAYS 10 If LESS than 1 day, hrs. or min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. AT HOME
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Russia

FATHER 13. NAME K. BAELOW

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Russia

MOTHER 15. MAIDEN NAME Fannie

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Russia

17. INFORMANT ABRAHAM COHN (ADDRESS) 2205 E 38

18. BURIAL, CREMATION, OR REMOVAL PLACE SHEFFIELD DATE MARCH 10 1939

19. FUNERAL DIRECTOR (NAME) J.P. LOUIS FUNERAL HOME (ADDRESS) CITY

20. FILED Memo 19 39 M. M. Crane Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) MARCH 9 1939
22. I HEREBY CERTIFY, That I attended deceased from 2 27, 1939, to 3 - 9, 1939
I last saw her alive on 3 - 9, 1939. Death is said to have occurred on the date stated above, at 9:30 A.M.
The principal cause of death and related causes of importance were as follows:

Cholemia
adynamic ileus
12/10

Date of onset

Other contributory causes of importance:
Intrabiliary Gall Stone

Name of operation Cholecystectomy Date of 3-2-39
What test confirmed diagnosis? Op Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) O. J. Prineas M.D.
(Address) 1024 Professional Bldg

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.

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

Registered Apprentice No., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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 this body is not embalmed, above space should be left blank.