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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

JAN 12 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41730

Registration District No. 791 1005

Primary Registration District No.

Registrar's No. 10853

1. PLACE OF DEATH:

(a) County 1

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Jewish Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 weeks (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1

(c) City or town St. Louis 12
(If outside city or town limits, write "RURAL")

(d) Street No. 4615 Lindell Blvd.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 45 yrs. years.

3. (a) PRINT FULL NAME David H. Cohen 5 M

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race Wh.

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Eva

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased May (Month) 15 (Day) 1885 (Year)

8. AGE: Years 54 | Months 7 | Days 4 | If less than one day ___ hr. ___ min.

9. Birthplace London (City, town, or county) England (State or foreign country)

10. Usual occupation Executive

11. Industry or business Iron

FATHER
12. Name Isaac Cohen
13. Birthplace London (City, town, or county) England (State or foreign country)

MOTHER
14. Maiden name Sarah Unknown
15. Birthplace London (City, town, or county) England (State or foreign country)

16. (a) Informant's own signature Wilton Waldman
(b) Address 7538 Buckingham Dr.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-39 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Olive Cemetery

18. (a) Signature of funeral director Herman Rudskopf
(b) Address 5216 Delmar Blvd.

19. (a) DEC 20 1939 (Date received local registrar) (b) J. F. Brodeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 19
year 1939 hour 4:30 minute A. M M.

21. I hereby certify that I attended the deceased from Dec-4-, 1939, to Dec-19, 1939;
that I last saw him alive on December-19, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Colon

Due to 46

Due to

Other conditions Secondary Haemorrhage
(Include pregnancy within 3 months of death)

Major findings: Of operations Ca-of Hepatic Flexion Primary

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)

While at work? (e) Means of injury

23. Signature J. G. Prolsteen (M. D. or other)

Address Fisher Bldg. Date signed 12/19/39

(Licensed Embalmer's Statement on Reverse Side)

14
1

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.....Charles Cooper.....

Licensed Embalmer No. 13830.....

P. O. Address 5216 Delmar

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

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