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S. No. 2
-1-4-41
5-17-39
PI X28390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

23786

State File No.

FILED AUG 28 1941 791

Registration District No. 1003

Registrar's No. 6128

1. PLACE OF DEATH:

(a) County.....
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Mos., 27 Days
(Specify whether
In this community 70yrs. 0 (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4240 Maryland Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country -- 0

3. (a) PRINT FULL NAME John Cohick

3. (b) If veteran, name war Unknown 3. (c) Social Security No. Unknown

4. Sex 0 Male 5. Color of race White 6. (a) Single, widowed, married, divorced 0 Single
6. (b) Name of husband or wife Single 6. (c) Age of husband or wife if alive Single years
7. Birth date of deceased August 17, 1865
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
75 11 2 hr. min.

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

10. Usual occupation Nil.

11. Industry or business Nil.

MOTHER FATHER { 12. Name Unknown

13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Ann Morrison

(b) Address St. Louis City Hospital #1.

17. (a) BURIAL (b) Date thereof 7-28-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVART

18. (a) Signature of funeral director hullen & Kelly

(b) Address 1416 N. Tenth and

19. (a) JUL 28 1941 (b) J. T. Ziegl
(Date of burial or removal) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19,
year 1941 hour 3:00 minute P. M.

21. I hereby certify that I attended the deceased from April 22, 1941 to July 19, 1941,
that I last saw him alive on July 19, 1941,
and that death occurred on the date and hour stated above.

Immediate cause of death Pyelo-nephritis
Chronic Duration

Due to Excysted Cystitis
Catarrhal

Due to 1340 1340
Other conditions (Include pregnancy within 3 months of death)

Major findings: Hypertrophy of Prostate
B. bladder stone
Of autopsy Excysted Pyelo-nephritis
& cystitis - Excep-halo-malacia
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?

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature [Signature] (M. D. or other) 0
Address 155 Lafayette Avenue Date signed 7/26/41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....

.....
working under my personal supervision.

Myself

..... Registered Apprentice No.

Signed..... *Clarence Henderson*

..... Licensed Embalmer No. *4141*

..... P. O. Address. *St. Louis Mo.*

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, fact should be so stated above.