

S. No. 2  
DM-5-43  
v. 5-17-39  
I X36671

32153

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED OCT 20 1944

1003

Registrar's No. 8632

Registration District No. 318 Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

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

(c) Name of hospital or institution: 1438 E. Grand  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1  
In this community 51 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County San  
17

(c) City or town St. Louis (If outside city or town limits, write "RURAL")  
9 9

(d) Street No. 1438 E. Grand  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Harris Cohen

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. no No. no

4. Sex male 0 5. Color or race white 6. (a) Single, widowed, married, divorced divorced

6. (b) Name of husband or wife Sarah Cohen 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 9 year 1944 hour 5 minute P. M.

21. I hereby certify that I attended the deceased from September 6, 1944, to October 9, 1944.  
that I last saw him alive on Oct. 9, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral embolism Duration 2 wks

Due to Generalized arteriosclerosis

Due to lv

Other conditions (Include pregnancy within 3 months of death) 83

8. AGE: abt 80 Years Months Days If less than one day hr. min.

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

10. Usual occupation night watchman

11. Industry or business \_\_\_\_\_

MOTHER, FATHER { 12. Name Benjamin Cohen

{ 13. Birthplace Lithuania (City, town, or county) (State or foreign country)

{ 14. Maiden name Sarah Riva Price

{ 15. Birthplace Lithuania (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ruth Aronson

(b) Address 6242 Southwood

17. (c) burial (b) Date thereof 10/11/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chesed Shel Emeth Berger Memorial

18. (a) Signature of funeral director 4715 McPherson ave.

(b) Address OCT 11 1944

19. (a) (Date received local registrar) J. R. Brudeck (Registrar's signature)

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? \_\_\_\_\_

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

23. Signature R. H. ... (M. D. or other) \_\_\_\_\_  
Address 3651 Grandel St Date signed 10-10-44

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

844

(Licensed Embalmer's Statement on Reverse Side)

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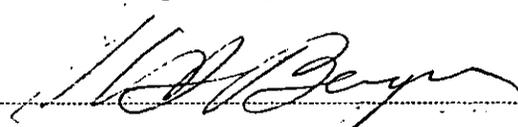
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

not embalmed

....., 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, fact should be so stated above..**