

S. No. 2
MOM-2-43
v. 5-17-39
X35597

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 6 1945
3 18

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7578
Registrar's No. 2665

Registration District No. _____

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County ST. LOUIS
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 5795 KINGSBURY - HOME 5
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 WKS
(Specify whether years, months or days)
In this community 33 YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 17
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 5795 KINGSBURY
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MOULIE COHEN

3. (b) If veteran, name war NO
3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced, widowed
6. (b) Name of husband or wife Late MORRIS COHEN
6. (c) Age of husband or wife if alive 10 years
7. Birth date of deceased Feb 10 1882
(Month) (Day) (Year)

8. AGE: Years 63 - Months 1 Days 13
If less than one day hr. min.

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

10. Usual occupation HOUSEWORK

11. Industry or business HOUSEWIFE

12. Name MORDICHA WALLACE

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

14. Maiden name GITTEL GOLDSMITH

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

16. (a) Informant Harry Cohen

(b) Address 163 42. Douthard

17. (a) BURIAL (b) Date thereof 3-23-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CHESED SHAL EMETH

18. (a) Signature of funeral director Odenbender

(b) Address 4469 Washington

19. (a) MAR 23 1945 (b) J. Fredesh
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 23
year 1945 hour 5 minute A.M.

21. I hereby certify that I attended the deceased from 1930 to March 1945
that I last saw her alive on March 23 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis Duration 6 days

Due to _____

Due to _____

Other conditions _____
(Includes pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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 Dr. [Signature] (M. D. or other) _____

Address 3651 Grand St Date signed 3-23-45

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Not Embalmed

Signed *J. J. Crank*
Licensed Embalmer No. *3669*
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.