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UNITED STATES HEALTH DEPARTMENT
STANDARD CERTIFICATE OF DEATH

11097

State File No. _____

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **3064**

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. 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 day**
(Specify whether _____)

In this community **40 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County _____

(c) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL")

(d) Street No. **1027 N. 94th ST.**
(If rural, give location)

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

3. (a) PRINT FULL NAME **PHILIP COHN - PHILIP**

3. (b) If veteran, name war _____

3. (c) Social Security No. **500-18-3363**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **4th**
year **1945** hour **9:40** minute **P.** M.

21. I hereby certify that I attended the deceased from **4/3/45**
_____, 19____, to **4/4/45**, 19____;

that I last saw him alive on **4/4/45**, 19____;
and that death occurred on the date and hour stated above.

4. Sex **MALE** 5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced **DIVORCED**

6. (b) Name of husband or wife _____

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

7. Birth date of deceased **UNKNOWN**
(Month) (Day) (Year)

Immediate cause of death **Myocardial Infarction**

Due to _____

Due to _____

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

8. AGE: Years **Abt 59** Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation **OPERATOR**

11. Industry or business **CLOTHING**

12. Name **ABRAHAM BERIL COHN**

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

14. Maiden name **MOELLE**

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

16. (a) Informant **Isadore Cohen**

(b) Address **7396 Grannelle**

17. (a) **BURIAL** (Burial, cremation, or removal) (b) Date thereof **4-6-45**
(Month) (Day) (Year)

(c) Place: burial or cremation **Chesed Shol EMEth**

18. (a) Signature of funeral director **[Signature]**

(b) Address **4469 Washington**

19. (a) **APR 6 1945** (Date received local registrar)

(b) _____ (Registrar's signature)

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? _____

23. Signature **[Signature]** 153 Lafayette 4/5/45 (Date received local registrar)

Address _____ Date signed _____

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

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. _____ Registered Apprentice No. _____

Signed *W. B. Reinhardt*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 3064

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: Edg Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Philip Cohen
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color W 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year _____

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

8. AGE Years abt-59 Months _____ Days _____ If less than one day _____ hr _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) MAY 1 1945 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town St Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1027 N 9th
(If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Month April day 4th
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that last saw h _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions (Include 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 _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTAL

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