

S. No. 2
DM-5-43
v. 5-17-39
I X38671

35502

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

FILED NOV 29 1945
318

STANDARD CERTIFICATE OF DEATH
1003

State File No. _____
Registrar's No. 9969

Registration District No. _____ 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:
Enroute to Jewish Hospital 3
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community 34 years 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. 1023 Hamilton av.
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 17
 year 1945 hour 2 minute 35 AM
 21. I hereby certify that I attended the deceased from
Jan, 1944, to Nov 17, 1945
 that I last saw him alive on Nov 5, 1945
 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 married
 6. (b) Name of husband or wife Mary Sharp
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased March 24, 1896
 (Month) (Day) (Year)

Immediate cause of death:
Coronary Occlusion
 Duration less than 1/2 hr

8. AGE:	Years	Months	Days	If less than one day
	<u>49</u>	<u>7</u>	<u>23</u>	_____ hr. _____ min.

Due to Hypertensive Cardiovascular Disease
 Due to _____

9. Birthplace Kamenetz Podolsk U.S.S.R.
 (City, town, or county) (State or foreign country)
 10. Usual occupation retail delicatessen

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

11. Industry or business _____
 12. Name Schloma Cohen
 13. Birthplace U.S.S.R.
 (City, town, or county) (State or foreign country)
 14. Maiden name Jocheved Paynuk
 15. Birthplace U.S.S.R.
 (City, town, or county) (State or foreign country)

Major findings:
 Of operations _____
 Of autopsy none
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Evelyn Roskin
 (b) Address 1023 Hamilton ave.
 17. (a) burial (b) Date thereof 11/18/45
 (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 _____
 19. (a) NOV 18 1945 (b) _____
 (Date received local registrar) (Registrar's signature)

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 Lister Tuholcke (M.D. or other) MD
 Address 462 N. Taylor Date signed 11/18/45

(Licensed Embalmer's Statement on Reverse Side) LISTER TUHOLSKE

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

MOTHER FATHER

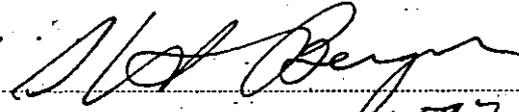
STATEMENT BY LICENSED EMBALMER

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.....



Licensed Embalmer No..... 1597

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.