

S. No. 2
M-5-43
5-17-39
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **93367**
Registrar's No. **1456**

FILED APR 10 1946

Registration District No. **7870** Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: Menorah Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Day (Specify whether years, months or days)

In this community 34 Years

3. (a) PRINT FULL NAME Mary Cohn

3. (b) If veteran, name war None

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 Wolff Cohn

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

7. Birth date of deceased Unknown

8. AGE: Years 71 Months Days If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

MOTHER, FATHER { 12. Name Alec

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

14. Maiden name Clara

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

16. (a) Informant Pete Cohn

(b) Address 444 Minnisota, K. C. Kan.

17. (a) Burial (b) Date thereof 3-27-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sheffield Cemetery

18. (a) Signature of funeral director J. P. Louis Funeral Home

(b) Address 3400 Woodland Ave., K. C., Mo.

19. (a) 3-27-46 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 3801 Montgall
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 26
year 1946 hour 4 minute 17 M.

21. I hereby certify that I attended the deceased from 24 Mar 1946 to 26 Mar 1946
that I last saw her alive on 26 Mar 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Chr. Myocarditis
Renal
Arteriosclerosis

Due to

Due to

Other conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:

Of operations

Of autopsy

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?

(Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address 1306 E 12 Date signed 26 Mar

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.....

B. A. Ryan

Licensed Embalmer No.....

3979

P. O. Address.....

TCMS

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.