

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

28547

FILED AUG 20 1946 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **6818**

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:
DePaul Hospital 0
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 1017
(d) Street No. 3611 Natural Bridge Ave
(If rural, give location) 9
(e) Citizen of foreign country? _____ (Yes or No) 19
If yes, name country _____

3. (a) PRINT FULL NAME

Leona M. Cohn

(b) If veteran, name war NO

(c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widow

(b) Name of husband or wife Isaac Cohn

(c) Age of husband or wife if alive Deceased years

7. Birth date of deceased August 1st, 1871
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
75 0 2 hr. 0 min.

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

10. Usual occupation Unemployed

11. Industry or business _____

12. Name Samuel Owens

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

14. Maiden name Cornelia Wilson

15. Birthplace St. Louis Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Harriet Cella

(b) Address 4605 Lindell Blvd

17. (a) Burial (b) Date thereof 8/5/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Robert J. Ambruster, Inc.

(b) Address 6633 Clayton Road

19. (a) AUG 4 1946 (b) J. F. Bredenk
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 3rd
year 1946 hour 7 minute _____ A.M.

21. I hereby certify that I attended the deceased from april 19 1946 to Aug 3 1946
that I last saw him alive on Aug 2 1946
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Duration _____

Cerebral Thrombosis
Due to _____ and Feb 24/46

Due to Diabetes Mellitus 22pp

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

Major findings:
Of operations _____

Of autopsy _____

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 J. R. Ferguson (M. D. or other) 220
Address 539 N. Grand Ave Date signed 8/3/46

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 Arnold W. Schoene

Licensed Embalmer No. 3864

P. O. Address St. Louis, Mo.

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.