S. No. 300
. 10.48

FILED JUL 5 1949

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 20888

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5343

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis
c. LENGTH OF STAY (in this place) 55yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Jewish Hosp. O

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo.
b. COUNTY 000
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis 10
d. STREET ADDRESS (If rural, give location) 946 Catalpa 10

3. NAME OF DECEASED (Type or Print) a. (First) LENA b. (Middle) c. (Last) COHEN

4. DATE OF DEATH (Month) (Day) (Year) June 20 1949

5. SEX Female /
6. COLOR OR RACE Whitem
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married /
8. DATE OF BIRTH Unk.
9. AGE (In years last birthday) Ab74 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Lithuania 8
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Jos. Lurie
13b. MOTHER'S MAIDEN NAME unk.
14. NAME OF HUSBAND OR WIFE Jacob

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME Hymen Cohen 946 Catalpa ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH 14 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerosis, generalized — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus — years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 97
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 4500

22. *I hereby certify that I attended the deceased from* June, 1947, *to* June 20, 1949, *that I last saw the deceased alive on* June 20, 1949 *and that death occurred at* 12:30 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE Max S. Franklin (Degree or title) M.D.
23b. ADDRESS 6341 Grand
23c. DATE SIGNED 6/20/49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 6/21/49
24c. NAME OF CEMETERY OR CREMATORY Beth Ham Hag. Cem
24d. LOCATION (City, town, or county) (State) Ladue Mo.

DATE REC'D BY LOCAL REG. JUN 21 1949
REGISTRAR'S SIGNATURE J. B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE Berger Memorial ADDRESS 4715 McPherson

(Licensed Embalmer's Statement on Reverse Side)

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.....

..... Student Embalmer No. .....,

working under my personal supervision.

Signed Lewis L Ludwig

Signed.....
Student Embalmer

Licensed Embalmer No. 4229

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.