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FILED APR 21 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13300**
2979

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (In this place) 47 yrs.		d. STREET ADDRESS (If rural, give location) 6030a Washington	
d. FULL NAME OF HOSPITAL OR INSTITUTION Enroute City Hosp.		5	

3. NAME OF DECEASED (Type or Print) a. (First) SAMUEL b. (Middle) A. c. (Last) COHEN			4. DATE OF DEATH (Month) (Day) (Year) Apr. 1, 1954		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Marr.	8. DATE OF BIRTH Mar. 16, 1902	9. AGE (In years last birthday) 52	IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant & locksmith.		10b. KIND OF BUSINESS OR INDUSTRY Retail Hardwe.		11. BIRTHPLACE (City and State or Foreign Country) USSR	12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Aaron Cohen	13b. MOTHER'S MAIDEN NAME Lena Sklar	14. NAME OF HUSBAND OR WIFE Mary
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. Unk.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mary Cohen 6030a Washington

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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		DUE TO (b) Coronary Thrombosis		
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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) 420.1
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Patrick E. Taylor Coroner		23b. ADDRESS 1300 Clark		23c. DATE SIGNED 4.2.54
24a. BURIAL, CREMATION, REMOVAL (Specify) Rem.	24b. DATE 4/14/54	24c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth	24d. LOCATION (City, town, or county) (State) University City Mo.	
DATE REC'D BY LOCAL REG. APR 2 1954	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Berger Memorial 4715 McPherson		

WRITE PLAINLY—USING 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.

Student
Student Embalmer

Student Embalmer No. _____
Signed *Arthur J. Dennis*
Licensed Embalmer No. *3988*

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.