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FILED JAN 14 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41404**
5682

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY **Jackson**

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE **Mo.** b. COUNTY **Jackson**

b. CITY OR TOWN **Kansas City** c. LENGTH OF STAY (in this place) **50 yrs.**

c. CITY OR TOWN **Kansas City** d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION **Benton Rest Home**

STREET ADDRESS (If rural, give location) **4223 Woodland**

3. NAME OF DECEASED
a. (First) **Lewis** b. (Middle) _____ c. (Last) **Cohn**

4. DATE OF DEATH (Month) (Day) (Year) **12-29-56**

5. SEX **M**

6. COLOR OR RACE **W**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **2**

8. DATE OF BIRTH **Approx 72**

9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Carpenter - Retired**

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and State or Foreign Country) **Russia**

12. CITIZEN OF WHAT COUNTRY? **U. S. A.**

13a. FATHER'S NAME **Menachem Mendel**

13b. MOTHER'S MAIDEN NAME **Milka Dayon**

14. NAME OF HUSBAND OR WIFE **Hannah**

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. **None**

17. INFORMANT'S SIGNATURE OR NAME ADDRESS **Mrs. David Ruttner Home**

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

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Unknown**

INTERVAL BETWEEN ONSET AND DEATH

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

ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) **General cachexia** rise to the above cause (a) stating the underlying cause last.

1 yr.

DUE TO (c)

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

1947

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)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR

22. I hereby certify that I attended the deceased from **Sept. 8, 1956**, to **Dec. 29, 1956**, that I last saw the deceased alive on **Dec. 10, 1956**, and that death occurred at **4 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE **G. W. Springer** (Degree or title) **D. O.**

23b. ADDRESS **5902 St. John ave. Kansas City, Mo.**

23c. DATE SIGNED **12-29-56**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Burial**

24b. DATE **12-30-56**

24c. NAME OF CEMETERY OR CREMATORY **Sheffield**

24d. LOCATION (City, town, or county) (State) **Kansas City, Mo.**

DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE **12-31-56 Vera Marshall**

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS **Louis Fun'l Home K.C. Mo.**

(Licensed Embalmer's Statement on Reverse Side)

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Wm. Ruffington*
Licensed Embalmer No. 275

P. O. Address..... *W.C.M.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.