

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10075**
2016

FILED MAR 28 1957

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 ST. LOUIS	
b. CITY OR TOWN St. Louis	c. LENGTH OF STAY (in this place) _____	c. CITY OR TOWN Jennings	d. In Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION 13 Incarnate Word Hospital		e. STREET ADDRESS (If rural, give location) 27 2301 Hord Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM	b. (Middle) P.M.	c. (Last) COHEN	4. DATE OF DEATH (Month) (Day) (Year) Feb 26 1957
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5. SEX 6 Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH April 19 1881	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Stock Clerk	10b. KIND OF BUSINESS OR INDUSTRY Dry Goods	11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo. 0	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Matthew Cohen	13b. MOTHER'S MAIDEN NAME Honora Head	14. NAME OF HUSBAND OR WIFE Deceased
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Mrs. Ruth Judd	ADDRESS 2301 Hord Ave.
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2-6 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) lobar pneumonia RT		
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) _____ rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____		

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION 490x	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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? _____
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22. I hereby certify that I attended the deceased from **Feb. 15, 1957, to Feb. 26, 1957**, that I last saw the deceased alive on **Feb. 26, 1957**, and that death occurred at **11:00 A.M.** on the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Chorann G. Dennis	23b. ADDRESS 1927 A main	23c. DATE SIGNED 2-27-57
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3/1/57	24c. NAME OF CEMETERY OR CREMATORY Calvary	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
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DATE REC'D BY LOCAL REG. FEB 28 57	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE SULLIVAN'S	ADDRESS 2849 No. Euclid Ave.
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(Licensed Embalmer's Statement on Reverse Side)

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

Dr. G. Brown

1927⁴ Union

Ed 55645

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 *Albert Grayfield*

Licensed Embalmer No. 3077

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