

FILED JUL 31 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

26016

Registration District No. **318** Primary Registration District **1003** Registrar's No. **6884**

300
1-56

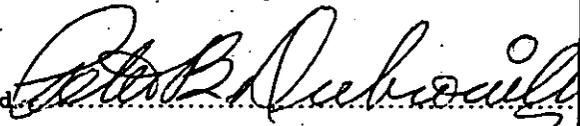
Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. **USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residency before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital		Length of stay in lb. 9 STREET ADDRESS 5806 Lotus (If outside, give location)	
3. NAME OF DECEASED (Type or print) IZAAK ^{First} COHEN ^{Last}		4. DATE OF DEATH Month July Day 22 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 75		10. KIND OF BUSINESS OR INDUSTRY Baker	11. BIRTHPLACE (City and state or country) Holland
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Marcus Cohen		14. MOTHER'S MAIDEN NAME Sophie Vanboevorden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 494-03-4873	
17. INFORMANT Abraham Mueller- Springfield-Ill		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE DUE TO (b) SPONTANEOUS PNEUMOTHORAX DUE TO (c) 520x Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CORONARY ARTERY DISEASE			INTERVAL BETWEEN ONSET AND DEATH 4 days
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from July 19, 1957 to July 22, 1957 and last saw her/him alive on July 22, 1957 . Death occurred at 19:15 p. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Robert Rubin M.D. (Degree or title)		22b. ADDRESS 216 S. KINGSHIGHWAY	
22c. DATE SIGNED July 23, 1957		23. NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State) Chesed Shel Emeth St. Louis County Mo.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE July 24, 1957	
24. FUNERAL DIRECTOR Herman Rindskopf Inc.		25. DATE RECD. BY LOCAL REG. JUL 23 57	
25. DATE RECD. BY LOCAL REG. JUL 23 57		26. REGISTRAR'S SIGNATURE J. Carl Smith M.D.	

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 

Licensed Embalmer No.

P. O. Address 

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.