

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-002825

STATE FILE NUMBER

2 454

FILED JAN 28 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

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1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Hamilton Conv. Home</b>		Length of stay in lb <b>70 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>2057 5590 Etzel</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>COHEN</b> Last			4. DATE OF DEATH Month <b>JAN.</b> Day <b>13,</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>	9. AGE (In years last birthday) <b>ab. 70</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done or of working life, even if retired) <b>Baker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Whistle Bky.</b>	11. BIRTHPLACE (City and state or country) <b>USSR</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Jacob Cohen</b>		13b. MOTHER'S MAIDEN NAME <b>(unk)</b>		14. NAME OF HUSBAND OR WIFE <b>Jennie</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> , or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unk.</b>	17. INFORMANT Address <b>Mrs. Ruth Adelstein 812 Eastgate</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Septicemia, Staphylococcal</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>skin decubiti</b> DUE TO (c) <b>Cerebral arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cerebral Vascular accident 2 yrs prior to death</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>2 yrs</b> <b>many years</b>
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 _____ a.m. _____ p.m. Month, Day, Year					
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 <b>July 25 1958</b> to <b>Jan 13 1959</b> and last saw her alive on <b>Jan 12 1959</b> Death occurred at <b>2:40 pm Jan 13 1958</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Herman J. Roodman M.D.</b>			22b. ADDRESS <b>15 N. Brentwood, Clayton, Mo</b>		22c. DATE SIGNED <b>Jan 14 1959</b>
23a. BURIAL, CREMATION, REINTERMENT (Specify)		23b. DATE <b>1/15/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Unshed Shel Emeth</b>		23d. LOCATION (City, town, or county) (State) <b>University City, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Berger Memorial 4715 Mc herson</b>			25. DATE RECD. BY LOCAL REG. <b>JAN 14 '59</b>	26. REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b> S.D.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

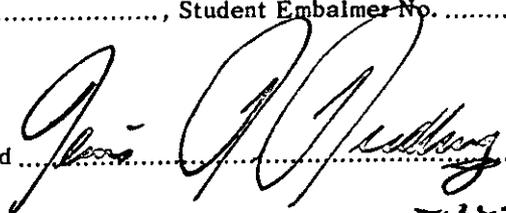
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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. 7227 .....

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.