

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002826

STATE FILE NUMBER

FILED FEB 10 1959

Registration District No.

Primary Registration District No.

Registrar's **8 1019**

300

1-57

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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, 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 Hosp.		d. STREET ADDRESS (If outside, give location) 1734 Washington	
3. NAME OF DECEASED (Type or print) First Middle Last SOL COHEN		4. DATE OF DEATH Month Day Year Jan. 27, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Unk.
10a. USUAL OCCUPATION (Give kind of work done or occupation if retired) Factory Employee		10b. KIND OF BUSINESS OR INDUSTRY Farm. Manf.	11. BIRTHPLACE (City and state or country) USSR
13a. FATHER'S NAME William Cohen		13b. MOTHER'S MAIDEN NAME Frieda (unk)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Mrs. Sylvia Flegel		Address 9625 Cutler	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) uremia DUE TO (b) nephrosclerosis DUE TO (c) arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Prostatic hypertrophy, chronic bronchitis			INTERVAL BETWEEN ONSET AND DEATH 10 days 10 days years
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.) 420.0	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <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 1953 to 1/27/59 and last saw him alive on 1/27/59 Death occurred at 8 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Max S. Franklin M.D.		22b. ADDRESS 634 N. Grand Ave.	
22c. DATE SIGNED 1/28/59			
23a. BURIAL, CREMATION, REMOVAL Rein.		23b. DATE 1/29/59	
23c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth		23d. LOCATION (City, town, or county) University City, Mo.	
24. FUNERAL DIRECTOR Berger Memorial 4715 McPherson		25. DATE RECD. BY LOCAL REG. JAN 29 '59	
26. REGISTRAR'S SIGNATURE Paul Smith, M.D.			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

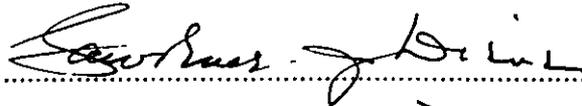
MEDICAL CERTIFICATION

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