

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-043108

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 531 Registrar's No. 3305

AMENDED

FILED NOV 30 1961

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived: If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>University City</u>		c. CITY OR TOWN <u>University City</u>	
Length of stay in lb <u>11 yrs.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>7299 Olive St. rd.</u>		d. STREET ADDRESS (If outside, give location) <u>1236 Midland</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>NATAN</u> Middle <u>COHEN</u> Last			4. DATE OF DEATH Month <u>Nov.</u> Day <u>21</u> Year <u>1961</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-18-1886</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Shop</u>	11. BIRTHPLACE (City and state or country) <u>Roumania</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Jacob Cohen</u>	13b. MOTHER'S MAIDEN NAME <u>Rachel (unk)</u>	14. NAME OF HUSBAND OR WIFE <u>Anna</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>Unk.</u>	17. INFORMANT <u>Anna Cohen</u> Address <u>1236 Midland</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
DUE TO (b) <u>arteriosclerosis, general</u>		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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.)
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20c. TIME OF INJURY Hour <u>2:30</u> a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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
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21. I attended the deceased from 10/16/36 to 11/21/61 and last saw ^{her}him alive on 11/12/61
Death occurred at 2:30 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deceased or title) <u>Max Franklin MD</u>	22b. ADDRESS <u>607 N. Grand Ave.</u>	22c. DATE SIGNED <u>11/21/61</u>
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23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <u>Bur.</u>	23b. DATE <u>11/22/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chevra Kadisha</u>	23d. LOCATION (City, town, or county) <u>University City, Mo.</u>
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24. FUNERAL DIRECTOR <u>Berger Memorial</u> ADDRESS <u>4715 McPherson</u>	25. DATE RECD. BY LOCAL REG. <u>11-21-61</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy MD.</u>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

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 *Lawrence J. Lewis*

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.