N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Montgomery

Township or Village Fairview / ~~Mexico~~ Mexico, Mo. Registration District No. 5-91 Primary Registration District No. 5749

File No. 5873

Registered No. 1

City ____ (NO. ____ St.: ____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME James Philip Cochran

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

DATE OF BIRTH Nov 25, 1891 (Month) (Day) (Year)

AGE 27 yrs. 8 mos. 1 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) on farm

BIRTHPLACE (City or town, State or foreign country) Gamma Mo.

PARENTS
NAME OF FATHER Wm H. Cochran
BIRTHPLACE OF FATHER (City or town, State or foreign country) Brown Co. Ohio
MAIDEN NAME OF MOTHER Nancy Jane Smith
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Brown Co. Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James E. Cochran

(ADDRESS) Gamma Mo.

Filed Feb 4, 1918. C. H. Rigg. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 4, 1918 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 18, 1917, to Dec 5, 1917, that I last saw ~~him~~ alive on Dec 5, 1917, and that death occurred, ~~on the date stated above~~ Feb. 4th 1918, at 2 P.M.

The CAUSE OF DEATH* was as follows:

28

1 Tuberculosis of the Lungs and Bowels

(Duration) 1 yrs. 9 mos. 11 ds.

Contributory (SECONDARY) Pneumonia

(Duration) 1 yrs. 1 mos. 1 ds.

(Signed) C. H. Elkins M. D.

Feb 4 1917 (Address) Gamma Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

PLACE OF BURIAL OR REMOVAL Gamma

DATE OF BURIAL Feb 4 1918

UNDERTAKER T. T. Jones

ADDRESS Middle Grove

MISSOURI STATE BOARD
BUREAU OF VITAL STA
CERTIFICATE OF DEA

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....
or
Village..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. .... St.; ..... Ward)

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... , 1.....
(Month) (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER.

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ..... , 191..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DE

DATE OF DEATH

.....
(Month)

I HEREBY CERTIFY, that I att

....., 191....., to.....

that I last saw h.....alive on.....

and that death occurred, on the date state

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.

Contributory.....
(SECONDARY)

.....(Duration).....yrs.

(Signed).....

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths (1) Means of Injury: and (2) whether Accidental, Suicida

LENGTH OF RESIDENCE (FOR HOSPITALS, INST RECENT RESIDENTS)

At place of death.....yrs. .....mos. .....ds. In the State.....

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL

UNDERTAKER