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

Do not use this space.

5792

Dr. Triplett

1. PLACE OF DEATH

County Cass — Registration District No. 156 — File No.

Township Grandmier — Primary Registration District No. 4090 — Registered No. 8

City Harrisonville (No. ..... St. ..... Ward)

2. FULL NAME Lena May Cochran

(a) Residence. No. ..... St., ... Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos. 7 ds. — How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
female	white	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ✓

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 10 1921

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	7	2	4	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work In school

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Appleton City
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Earl Cochran

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Kingsville
(STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Mary Resz

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Harrisonville
(STATE OR COUNTRY) Missouri

14. INFORMANT Earl Cochran
(Address) Harrisonville Mo

15. FILED 7/17, 1929 D. Slong REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 14 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb. 13, 1929, to Feb 14, 1929 that I last saw her alive on Feb. 14, 1929, and that death occurred, on the date stated above, at 3:00 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7 Measles

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (SECONDARY)

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. S. Triplett, M. D.

, 19 (Address) Harrisonville, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Orient	2/15 1929

20. UNDERTAKER	ADDRESS
Rummenburger Bros Co	Harrisonville Mo.

Dr Triplett

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.

Apr 1 1929

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