106

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

Do not use this space. 36084 ~~36010~~

1. PLACE OF DEATH
County: Taney — Registration District No.: 1065 — File No.: 33
Township: Jasper — Primary Registration District No.: 6133 — Registered No.:
City: (No. ..., ... St. ..... Ward)

2. FULL NAME: Mary Ann Cochran
(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Jerry Cochran

6. DATE OF BIRTH (MONTH, DAY AND YEAR): May 22 1848

7. AGE: YEARS 81 — MONTHS 4 — DAYS 17 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Iowa

PARENTS
10. NAME OF FATHER: Packer
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Don't Know
12. MAIDEN NAME OF MOTHER: Don't Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Don't Know

14. INFORMANT: W. J. Jones
(Address): Reeds Spring Mo

15. FILED: Oct 10 1929 T. C. Stewart, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR): Oct 9 1929

17. I HEREBY CERTIFY, That I attended deceased from Sept 26, 1929, to Oct 6, 1929 that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 7 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral Insufficiency
90A
(duration) 5 yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Catarrh of Stomach
(duration) 1 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 92A 118C
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) L. D. Dennis, M. D
10/10/1929 (Address) Reeds Spring 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: Gretna — DATE OF BURIAL: Oct 10 1929

20. UNDERTAKER: W. J. Jones acting — ADDRESS: Reeds Spring Mo

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.

WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD