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

Do not use this space.

19935

JUL 23 1930

1. PLACE OF DEATH
County Lincoln — Registration District No. 486 — File No.
Township — Primary Registration District No. 4293 — Registered No. 19
City Elsberry (No. ..... St. ..... Ward)

2. FULL NAME Katherine H. 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 yrs. mos. 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)
F.	W.	W.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 12 - 1851

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	78	10	15	

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) Paynesville Mo
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Wm Hemphill
11. BIRTHPLACE OF FATHER (CITY OR TOWN) KY
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Mary Boon
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) K.Y.
(STATE OR COUNTRY)

14. INFORMANT Mrs W. R. Cannon
(Address) Elsberry Mo

15. FILED 7-10, 19 C. E. Powell Mo
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-27- 1930

17. I HEREBY CERTIFY, That I attended deceased from June 27, 1930, to June 27, 1930 that I last saw her alive on June 27, 1930, and that death occurred, on the date stated above, at 10 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Congestion (passive)
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (SECONDARY) leakage heart (probably myocarditis).
(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? none
(Signed) F. F. Keeling, M. D
, 19 (Address) Elsberry, 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
Clarksville Cemetery	June 24 1930

20. UNDERTAKER	ADDRESS
W. D. Bradley	Elsberry

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.