

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

Do not use this space.

26829

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Kaw Primary Registration District No. 1002
City St. Joseph, Mo. 1019 Forest
Little Louisa St. _____ Ward)

File No. _____
Registered No. 3434
St. _____ Ward)

2. FULL NAME

Lilla Louise Cochran
(a) Residence. No. 1019 Forest St. 2 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 F 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 14, 1853

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
76 11 3

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) Steubenville
(STATE OR COUNTRY) Ohio

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Wich Webb

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) _____

14. INFORMANT Chas M Cochran
(Address) RR #6 - St Joseph Mo

15. FILED 8/19 1930 M. M. C. Howe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 17 1930

17. I HEREBY CERTIFY, That I attended deceased from August 7, 1930 to Aug 17, 1930
that I last saw alive on 8/17/30, 1930, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage

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

CONTRIBUTORY (SECONDARY) 74001
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Chemical analysis

(Signed) R. C. Coffey, M. D.

7-18, 1930 (Address) 1103 9th St

*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 Atchison Kans DATE OF BURIAL Aug 19 1930

20. UNDERTAKER D. H. Newcomer's Sons ADDRESS 1103 9th St

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 LABEL, WITH WRAPPING INK—THIS IS A PERMANENT RECORD

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