NOV 25 1930

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

Do not use this space.

1. PLACE OF DEATH

County: Jasper — Registration District No.: 411 — File No. 33319

Township: — Primary Registration District No.: 2002 — Registered No.:

City: Joplin (No. ... St. ... Ward)

2. FULL NAME: Mrs. Grace Cochrane

(a) Residence. No. Freeman Hospital Ward. Carterville, Mo.
(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)
Female	White	Married

5A. IF MARRIED, ~~WIDOWED OR DIVORCED~~ ~~HUSBAND OF~~ (OR) WIFE OF L. N. Cochrane

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 24-1881

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ... min.
49	7	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Monroe County (STATE OR COUNTRY) Iowa

PARENTS
10. NAME OF FATHER Jack Reed
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Penn
12. MAIDEN NAME OF MOTHER Mary E. Howard
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Iowa

14. INFORMANT L. N. Cochrane (Address) Carterville Mo.

15. FILED 10/31, 1930 Benson Clark REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 29 1930

17. I HEREBY CERTIFY, That I attended deceased from 10/24/30, 1930, to 10/29/30, 1930, that I last saw h. alive on 10/29/30, 1930, and that death occurred, on the date stated above, at 7:45 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral meningitis
ETIOLOGY
PATHOGENESIS (duration) Days/weeks. yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Chronic mastoid infection left ear (duration) days/weeks. yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED home
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No.
WHAT TEST CONFIRMED DIAGNOSIS? X-Ray
(Signed) E. A. Tomlinson, M. D.
10/31, 1930 (Address) Joplin 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
Mt. Hope Cemetery	Nov 1 1930
20. UNDERTAKER	**ADDRESS**
West City Und. Co.	West City

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.