

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

17000
Do not use this space.

1. PLACE OF DEATH

(a) County..... / Registration District No..... **791**
 (b) Township..... Primary Registration District No..... **1003** Registered No..... **4534**
 (c) City or St. Louis, Mo. (d) Street No. De Paul Hospital St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Ruth Ann Cochran
 (a) Residence, No. 7010 Garesche St. **NR** St. Louis County
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 17, 1939
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. _____

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Nil
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) St. Louis
 (STATE OR COUNTRY) Missouri

13. NAME William Cochran

14. BIRTHPLACE (CITY OR TOWN) Poplar Bluff
 (STATE OR COUNTRY) Missouri

15. MAIDEN NAME Evlyn Soley

16. BIRTHPLACE (CITY OR TOWN) Missouri
 (STATE OR COUNTRY) _____

17. INFORMANT William Cochran
 (ADDRESS) 7010 Garesche

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Memorial Park DATE 5 /18/1939

19. FUNERAL DIRECTOR (NAME) Edith E. Ambruster
 (ADDRESS) 4234 Manchester

20. FILED 18 1939 J. B. Braddock
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 17, 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
 I last saw h..... alive on _____, 19____. Death is said to have occurred on the date stated above, at 555A.
 The principal cause of death and related causes of importance were as follows:

Still born cause undetermined

Date of onset

Other contributory causes of importance: _____
 Name of operation None Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? No Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) Quas Post, M. D.
 (Address) 3500 Delgrand

MAY 18 1939

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

50M-9-19-38 I X16005

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Not embalmed

Signed..... *Florence Eymek*
Licensed Embalmer No..... *1284*
P. O. Address..... *St Louis Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)
If this body is not embalmed, above space should be left blank.