DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 16 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32334

Registration District No. 5-912 Primary Registration District No. 5960B Registrar's No. 42

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County RALLS

(b) City or town RURAL - ~~RALLS~~ - JASPER
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 5 Mi North VANDALIA.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community 80 YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County RALLS

(c) City or town RURAL JASPER TWS
(If outside city or town limits, write "RURAL")

(d) Street No. 5 MILE NORTH VANDALIA
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME JOSEPH COCHRAN

3. (b) If veteran, name war ..... 3. (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife ..... 6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased FEBRUARY (Month) 4 (Day) 1861 (Year)

8. AGE: Years 80 Months 7 Days 26 If less than one day ..... hr. ..... min.

9. Birthplace RALLS Co. (City, town, or county) MISSOURI (State or foreign country)

10. Usual occupation FARMER

11. Industry or business .....

FATHER
12. Name JAMES COCHRAN
13. Birthplace ..... (City, town, or county) MISSOURI (State or foreign country)

MOTHER
14. Maiden name ELIZABETH SHULTZE
15. Birthplace ..... (City, town, or county) MISSOURI (State or foreign country)

16. (a) Informant Mrs. Cleve Ledford
(b) Address Vandalia, Missouri

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT 1 1941 (Month) (Day) (Year)
(c) Place: burial or cremation MOUNT AIR CEMETERY

18. (a) Signature of funeral director W. S. Waters
(b) Address Vandalia, Missouri

19. (a) Oct 3 1941 (Date received local registrar) (b) R. Lee Alford M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 30 year 1941 hour 7:30 minute A M.

21. I hereby certify that I attended the deceased from July 15 1941, to Sept 30 1941; that I last saw him alive on Sept 28 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute Endocarditis	2 wks.
Due to Chronic diffuse Interstitial nephritis	5 yrs.
Due to ~~Paralysis~~	
Other conditions Paralysis of lower extremities due to Cord injury (Include pregnancy within 3 months of death)	
Major findings: Of operations ..... Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) .....
(b) Date of occurrence .....
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature R L Marshall (~~M.D. or~~ other) D.O.
Address Vandalia Date signed Oct 3, 41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 10-41-1830
Date Filed _____

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.

Signed Wm. B. Waterd

Licensed Embalmer No. 4169

P. O. Address Vandalia Ill

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, fact should be so stated above.

No. 2B
-8-21-41
I X29288

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32334

Registration District No. 912 ~~87~~

Primary Registration District No. 5960B

Registrar's No.

1. PLACE OF DEATH:

(a) County: Ralls

(b) City or town: Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Joseph Cochran

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: W

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased: Feb 4, 1861 (Month) (Day) (Year)

8. AGE: Years 80 Months 7 Days 18 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) Nov 14 1941 (Date received local registrar) (b) R. Lee Alsup M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 30 year 1941 hour 0 minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Endocarditis

Due to: Chronic diffuse Interstitial nephritis

Due to:

Other conditions (Include pregnancy within 3 months of death): Paralysis of lower extremities due to cord injury

Major findings:
Of operations

Of autopsy: 131a

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify): accidental

(b) Date of occurrence: 1926

(c) Where did injury occur? Clay Pendleton Adair Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place): while working in Brick yard.

While at work? yes (e) Means of injury: fall

23. Signature: Dr. R.P. Marshall (Mr. Dr or other) DO

Address: Vandalia Mo. Date signed: Nov 14

SUPPLEMENTARY