

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

BUREAU OF THE CENSUS
FILED NOV 18 1941

Registration District No. 614

Primary Registration District No. 5816

Registrar's No. 20

1. PLACE OF DEATH:

(a) County Newton
(b) City or town Franklin
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County 73
(c) City or town.....
(If outside city or town limits, write "RURAL") 0
(d) Street No.....
(If rural, give location) 0
(e) Citizen of foreign country?..... (Yes or No) 0
If yes, name country.....

3. (a) PRINT FULL NAME Meloda Jane Cochran

3. (b) If veteran, name war..... 3. (c) Social Security No. 2

4. Sex Female 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

7. Birth date of deceased Aug 23 - 1854
(Month) (Day) (Year)

8. AGE: Years 87 Months 1 Days 14 If less than one day
hr. min.

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

10. Usual occupation Housekeeper

11. Industry or business.....

12. Name Nathan Beck

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

14. Maiden name Sarah Hatcher

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

16. (a) Informant W. H. Williams

(b) Address Franklin Mo

17. (a) Burial (b) Date thereof Oct 6 - 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation 2 mi South of Franklin

18. (a) Signature of funeral director W. H. Williams

(b) Address Franklin Mo

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 4
year 1941 hour 8 minute 30 P. M.

21. I hereby certify that I attended the deceased from 10-2-41
10-4- 1941 to 10 2 1941;
that I last saw her alive on 10 2 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Mitral Insufficiency

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death) 92b

Major findings:
Of operations.....

Of autopsy.....

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 W. H. Williams (M. D. or other) Parson Mo

Address Franklin Mo Date signed 10.4.41

Duration

2 H

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 6,

District File Number 1141-1740

Date Filed NOV 14 1941

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35618
Registrar's No. _____

Registration District No. 614

Primary Registration District No. 5816

1. PLACE OF DEATH:

(a) County Newton
(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
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Newton
(c) City or town Barney R 2
(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 Malenda J. Cochran

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 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 Aug 23
(Month) (Day) (Year)

8. AGE: Years 87 Months 1 Days 24 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 10-4-41 (b) R. E. Riley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him/her alive on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions _____ (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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

S-35618