

State File No. _____

FILED MAR 8 1943
Registration District No. 54

Primary Registration District No. 5189

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Osan (rural) Welch
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: hosp
(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 Cape Girardeau
(c) City or town Osan "rural"
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME

Benson Boyd Cochran

(b) If veteran, name war _____

(c) Social Security No. _____

4. Sex MO

5. Color or race W

6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: Jan 16 1943
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____
If less than one day: 3 hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Ernest Cochran

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

14. Maiden name Mattie Crowder

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

16. (a) Informant Ernest Cochran

(b) Address Osan Mo

17. (a) Burial (b) Date thereof 1-17-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bearwood Cem

18. (a) Signature of funeral director None
(b) Address _____

19. (a) 2/23/43 (b) A. H. Marke
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 17
year 1943 hour 12 minute 30 A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him alive on 1/16, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Premature Birth

Due to 9

Due to _____

Other conditions: 75
(Include pregnancy within 3 months of death)

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? _____

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

23. Signature J. A. Clines (M. D. or other)
Address Osan Mo Date signed 4/17/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 4

District File Number 343-180

Date Filed 3-4-43

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 complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.