

FILED JAN 10 1944

Registration District No. 83

Primary Registration District No. 3010

Registrar's No. 407

1. PLACE OF DEATH:

(a) County Cape Girardeau  
(b) City or town Cape Girardeau  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Francis Hosp  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 1/2 hr.  
(Specify whether  
In this community 4 hour  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME James Henry Cochran

3. (b) If veteran: name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased Dec. 19, 1943  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 4 1/2 hr. min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Ernest Cochran

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

14. Maiden name Mattie Crowden

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

16. (a) Informant Mrs Jennie Crowden

(b) Address Rural Mo

17. (a) BURIAL (b) Date thereof 12-20-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fairview Near Arbor Mo.

18. (a) Signature of funeral director B. Stimpinger Hubbers  
(b) Address Chaffee Mo

19. (a) 12-21-43 (b) J. W. Phelps  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 19  
year 1943 hour 3 minute 0 M.

21. I hereby certify that I attended the deceased from 12-19-43  
to 12-19 1943  
that I last saw him alive on 12-19-43  
and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory Failure  
Maternal Cervical Disease  
Duration \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 159  
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 W. T. Chaffee (M. D. or other)  
Address Chaffee Mo Date signed 12/20/43

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

16  
1  
4

RECEIVED

Health Officer No. 4

Number 144-3178

1-7-44

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 <sup>not</sup>.....

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Marice Broderick Hoff

Licensed Embalmer No. 3242

P. O. Address Chaffee 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, fact should be so stated above.