

Registration District No. _____

Primary Registration District No. 3045

Registrar's No. 27

1. PLACE OF DEATH:

(a) County Mississippi
(b) City or town Charleston,
(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 All Of Life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi 67
(c) City or town Charleston, (If outside city or town limits, write "RURAL") 3
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____ 0

3. (a) PRINT FULL NAME Infant Cockran

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

7. Birth date of deceased March 19th 1944
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 2 hr. _____ min.

9. Birthplace Charleston, Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Noel Cockran

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

14. Maiden name Eva Riley

15. Birthplace Gatewood Mo. 0 (City, town, or county) (State or foreign country)

16. (a) Informant Noel Cockran

(b) Address Charleston, Mo.

17. (a) Burial (b) Date thereof 3-22-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove, Charleston, Mo.

18. (a) Signature of funeral director [Signature]

(b) Address Charleston, Mo.

19. (a) Em. 1/4 (b) Mrs. [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 21
year 1944 hour 10 minute A. M.

21. I hereby certify that I attended the deceased from on Mar 19 1944 to Mar 21 1944
that I last saw him alive on Mar 21 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Congenital heart
Due to _____

Due to _____
Other conditions None
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

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) _____
(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 [Signature] (M. D. or other) _____
Address Charleston, Mo. Date signed 3/22/44

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

07
2

1257

RECEIVED

District Health Office No. 2,

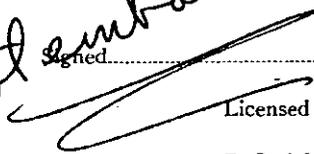
District File Number 444-368

Date Filed 4-4-44

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.....

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

not embalmed
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.