

S. No. 2
DM-243
V. 5-1739
P-1 X35697

State File No. _____
Registrar's No. **209**

REG. FEB 6 1945 149
Registration District No. _____

Primary Registration District No. **1602**

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

1. PLACE OF DEATH:

(a) County **Jackson,**

(b) City or town **Kansas City,**

(c) Name of hospital or institution: **General Hospital**
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution **1 day**
(If not in hospital or institution, write street number or location)

In this community **all its life** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Aritta Baby Mary Aritta Cochran**

3. (b) If veteran, name war **X**

3. (c) Social Security No. **X**

4. Sex **Female**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **Child**

6. (b) Name of husband or wife **X**

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

7. Birth date of deceased **August 10 1943**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
- 1	5	4	hr. _____ min.

9. Birthplace **Missouri** (State or foreign country)

10. Usual occupation **child**

11. Industry or business **X**

12. Name **Irvin Cochran**

13. Birthplace **Missouri** (State or foreign country)

14. Maiden name **Ina Hill** (State or foreign country)

15. Birthplace **Missouri** (State or foreign country)

16. (a) Informant **Irvin Cochran,**

(b) Address **2603 E. 70th St., Kansas City, Mo**

17. (a) **Burial** (b) Date thereof **1-17-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Greenlawn Cemetery**

18. (a) Signature of funeral director **Stine & McClure,**

(b) Address **3235 Gillham Plaza, Kansas City, Mo.**

19. (a) **1-15-45** (b) **J. E. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson,**

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

(d) Street No. **2603 East 70th St.,**
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **1** day **14**
year **1945** hour **10:20** minute **A** M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw him _____ live _____ and that death occurred on the date and hour stated above.

Immediate cause of death **Diphtheria**

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations **Heart & Lung**

Of autopsy **no!**

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. E. Brown** (M.D. or other) _____
Date signed **1-14-45**

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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..... *Robert H Reed*

Licensed Embalmer No. *3745*

P. O. Address..... *Kansas City 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.