

FILED MAR 24 1945
Registration District No. **199**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution St. Joseph Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 day
(Specify whether)

In this community 7 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson Co.

(c) City or town Independence
(Outside city or town limits, write "RURAL")

(d) Street No. 2912 Forest
(If rural, give location)

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

3. (a) PRINT FULL NAME RUBY M COCHRAN

3. (b) If veteran, name war no

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 9
year 1945 hour _____ minute _____ M.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Clyde Cochran

6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased August 13 1893
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 3/6
1945 to 3/9/45 1945
that I last saw her alive on 3/8 1945
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>51</u>	<u>6</u>	<u>26</u>	hr. _____ min.

Immediate cause of death:
Carcinomatosis of Abdomen & Intestinal Obstruction (Partial)
Carcinoma of Cervix Uteri

Due to _____

Due to _____

Duration 67000

9. Birthplace Iowa 1
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Elnora Downing

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

14. Maiden name Martha Scholtz

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

16. (a) Informant Leo Cochran

(b) Address 2912 Forest

17. (a) Burial (b) Date thereof 3 12 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director Leo C. Cochran

(b) Address Independence Mo

19. (a) 3-10-45 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

Other conditions 480
(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) (Specify type of place)

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

Address 318 Prof. Bldg. Date signed 3/10/45

APR 9 1945

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 *Floyd L. Brown*.....

Licensed Embalmer No. *4199*.....

P. O. Address *Independence, 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.