. S. No. 2
OM—8-43
v. 5-17-39
I X37823

#42399

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

15019

State File No.

FILED JUN 9 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4898

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

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis, Missouri (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis City Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days (Specify whether
In this community 30 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 126
(d) Street No. 1948 No. Broadway (If rural, give location)
(e) Citizen of foreign country? No 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Cora Cochran
3. (b) If veteran, name war No
3. (c) Social Security No. No
4. Sex Fem 1
5. Color or race W
6. (a) Single, widowed, married, divorced Single 0
6. (b) Name of husband or wife xx
6. (c) Age of husband or wife if alive xx years
7. Birth date of deceased Feb. (Month) 28 (Day) 1878 (Year)

8. AGE: Years 67 Months 3 Days 2 If less than one day hr. min.

9. Birthplace x x (City, town, or county) Tenn. 1 (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name Jasper C ochren
13. Birthplace xx (City, town, or county) Kentucky 1 (State or foreign country)
MOTHER
14. Maiden name Millie Gordon
15. Birthplace x x (City, town, or county) Kentucky 1 (State or foreign country)
16. (a) Informant Julia Ra sful
(b) Address 82 5 Des trahan
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/1/45 (Month) (Day) (Year)
(c) Place: burial or cremation St. Ma tthews
18. (a) Signature of funeral director A. W. McLaughlin
(b) Address 230 1 Lafeyette
19. (a) JUN 1 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 30th year 1945 hour 6:40 minute P. M.
21. I hereby certify that I attended the deceased from 5/23/45, 19..., to 5/30/45, 19...; that I last saw her alive on 5/30/45, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) 83

Major findings:
Of operations
Of autopsy Refused

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature Herbert C. Fritz (M. D. or other) 0
Address 1515 Lafayette Date signed 5/31/45

(Licensed Embalmer's Statement on Reverse Side)

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 L. H. Cooper

Licensed Embalmer No. 3633

P. O. Address 2317 Lafayette

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.