

**FILED JUN 12 1945**  
Registration District No. **5-2**

Primary Registration District No. **3006**

Registrar's No. **134**

**1. PLACE OF DEATH:**

(a) County **Boone**

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

(c) Name of hospital or institution: **Noyes Hospital** **D**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **4 days** (Specify whether years, months or days)

In this community **52 years** (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Missouri** (b) County **Boone**

(c) City or town **Columbia Rural 10**  
(If outside city or town limits, write "RURAL")

(d) Street No. **R. F. W. #3**  
(If rural, give location)

(e) Citizen of foreign country? **No.** (Yes or No)

If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** **LOYD COCHRAN**

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

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

**6. (b) Name of husband or wife** **Mattie Cochran** **6. (c) Age of husband or wife if alive** **39** years

**7. Birth date of deceased** **12-21-1892**  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<b>52</b>	<b>4</b>	<b>11</b>	hr. _____ min. _____

**9. Birthplace** **Boone Co Mo.**  
(City, town, or county) (State or foreign country)

**10. Usual occupation** **Farmer**

**11. Industry or business** **Farm**

**12. Name** **Mose Cochran**

**13. Birthplace** **Boone Co. Mo.**  
(City, town, or county) (State or foreign country)

**14. Maiden name** **Mary Sexton**

**15. Birthplace** **Boone Co. Mo.**  
(City, town, or county) (State or foreign country)

**16. (a) Informant** **Mattie Cochran**

**(b) Address** **Columbia Mo.**

**17. (a) Burial** **(b) Date thereof** **5-9-1945**  
(Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation** **Hinton Mo.**

**18. (a) Signature of funeral director** **Stuart P. Parker**

**(b) Address** **Columbia Missouri**

**19. (a) 5-16-1945 (b) E. C. H. Barber**  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month **May** day **2**  
year **1945** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

**21. I hereby certify that I attended the deceased from** **4** - **15** - **1945** to **5** - **2** - **1945**  
that I last saw him alive on **5** - **2** - **1945**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Stenosis** **Duration** **6 days**

Due to **Following Lab. Findings** **4 days**

Due to \_\_\_\_\_

Other conditions **First had a cerebral**  
(Include pregnancy within 3 months of death)  
**hemorrhage - Jan. 45.**

Major findings: **None** **PHYSICIAN** \_\_\_\_\_  
Of operations **None**  
Of autopsy **None**  
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)** **None**

**(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? **None** (Specify type of place) **(e) Means of injury** **None**

**23. Signature** **W. P. [Signature]** (M. D. or other) **MD**

Address **Columbia Mo.** Date signed **5-11-45**

1250

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 6-11-45

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 Sharon D. Parker

Licensed Embalmer No. 2900

P. O. Address Columbia, 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.**