S. No. 2
1—8-43
5-17-39
P I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

J. H. Cochran

State File No. 20047

FILED JUL 9 1945

Registration District No. [illegible] Primary Registration District No. 3010. Registrar's No. 186.

1. PLACE OF DEATH:
(a) County: Cape Girardeau
(b) City or town: Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Vincent's Missouri
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 Days (Specify whether years, months or days)
In this community ~~6 days 9 months, 11 days~~

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: New Madrid
(c) City or town: Portageville
(If outside city or town limits, write "RURAL")
(d) Street No.: 1 (If rural, give location) 0
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Michael Jas LaFerney
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: Single
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: September (Month) 4 (Day) 1944 (Year)
8. AGE: Years: 9 Months: 11 Days: If less than one day: hr. min.
9. Birthplace: Cape Girardeau (City, town, or county) — Missouri (State or foreign country)
10. Usual occupation:
11. Industry or business:
12. Name (Father): Phineas LaFerney
13. Birthplace (Father): Cogran (City, town, or county) Missouri (State or foreign country)
14. Maiden name (Mother): Ethel Fisher
15. Birthplace (Mother): Hayward (City, town, or county) Missouri (State or foreign country)
16. (a) Informant: Phineas LaFerney
(b) Address: Portageville Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: June 18 1945 (Month) (Day) (Year)
(c) Place: burial or cremation: Portageville Cemetery
18. (c) Signature of funeral director: Payne & Lyle
(b) Address: Portageville Mo
19. (a) 6-22-45 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 17th year 1945 hour 5 minute 15 17 M.
21. I hereby certify that I attended the deceased from June 12th, 1945, to June 17th, 1945, that I last saw him alive on June 16, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Lobar pneumonia	10 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations: No
Of autopsy:

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: J. H. Cochran (M. D.)
Address: Cape Girardeau Mo Date signed 6/19/45

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

1014 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 745-821

Date Filed 7-6-45

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 Not Embalmed, Registered Apprentice No. ....., working under my personal supervision.

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.

S. No. 2B
5M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. July

Registration District No. 153 Primary Registration District No. 3010 Registrar's No. 188

1. PLACE OF DEATH:

(a) County: Cape Girardeau

(b) City or town: Cape Girardeau
(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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

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

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

3. (a) PRINT FULL NAME: Michael J. Lafuney

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: S

6. (b) Name of husband or wife

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

7. Birth date of deceased: Sept (Month) 4 (Day) 1944 (Year)

8. AGE: Years 1 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 6-22-45 (Date received local registrar) (b) F. W. Phelps (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 7 year 1945 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

S-20047