7. S. No. 2
0M—5-42
ev. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 15 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30658

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 97

1. PLACE OF DEATH:
(a) County Howell
(b) City or town West Plains
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: West Plains Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Day (Specify whether years, months or days)
In this community 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State ARKANSAS (b) County FULTON 999
(c) City or town "RURAL" CAMP. 3
(If outside city or town limits, write "RURAL")
(d) Street No. R.R. 2. KOSHKONONG, Mo. 0
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No) 2
If yes, name country

3. (a) PRINT FULL NAME MYRTLE DORIS COCHRAN
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Female 1
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Roy Cochran
6. (c) Age of husband or wife if alive 49 years
7. Birth date of deceased Feb. (Month) 1, (Day) 1920 (Year)

8. AGE: Years 25 Months 6 Days 21 If less than one day hr. min.

9. Birthplace Fulton Co., (City, town, or county) Arkansas (State or foreign country)
10. Usual occupation Housewife.
11. Industry or business

FATHER
12. Name Charles Fuller
13. Birthplace Howell Co., (City, town, or county) Mo. 0 (State or foreign country)

MOTHER
14. Maiden name Dora Lau
15. Birthplace Fulton Co., (City, town, or county) Ark. 1 (State or foreign country)

16. (a) Informant Roy Cochran
(b) Address Koshkonong, Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug 23 1945 (Month) (Day) (Year)
(c) Place: burial or cremation CAMP, Ark.
18. (a) Signature of funeral director J B Caldwell
(b) Address Salem Ark
19. (a) Sept. 14, 1945 (Date received local registrar) (b) Gladys Harrison (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUG. day 22 year 1945 hour 7 minute 8 P.M.
21. I hereby certify that I attended the deceased from 8/21, 1945 to 8/22, 1945 that I last saw her alive on 8/22, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Peritonitis	
Due to Rupt appendix	
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) X
(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 0

23. Signature Maurice Thompson (M. D. or other) M D
Address West Plains Mo Date signed 9/13/45

15 19 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer, No. 5,
District File Number 1045-S-09
Date Filed 10-13-45

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 Hal Thornburgh

Licensed Embalmer No. 3408

P. O. Address West Plains, M

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.