

No. 2
1-5-43
5-17-39
I X36671

State File No.

Registrar's No.

FILED JAN 11 1946
Registration District No. 3181

Primary Registration District No. 1003

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD
2402

1. PLACE OF DEATH:

(a) County.....St. Louis

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

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

(d) Length of stay: In hospital or institution.....11 days
(Specify whether years, months or days)

In this community.....10 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME.....POMP COCHRAN

3. (b) If veteran, name war.....--

3. (c) Social Security No.....--

4. Sex.....Male 2

5. Color or race.....Negro

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

6. (b) Name of husband or wife.....Nicie

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

7. Birth date of deceased.....Abt 1866
(Month) (Day) (Year)

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

Abt 80 hr. min.

9. Birthplace.....Hungtington Tenn.
(City, town, or county) (State or foreign country)

10. Usual occupation.....Laborer

11. Industry or business.....

MOTHER FATHER

12. Name.....Unknown

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

14. Maiden name.....Unknown

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

16. (a) Informant.....Sylvester Mitchell

(b) Address.....4116 W. Belle

17. (a) Removal (b) Date thereof.....1-10-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....Dresden, Tenn.

18. (a) Signature of funeral director.....Chas. J. Gates

(b) Address.....4107 Finney Ave.

19. (a) JAN 10 1946 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State.....Mo. (b) County.....St. Louis

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

(d) Street No.....4116 W. Belle
(If rural, give location)

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

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month.....Jan. day.....7th
year.....1946 hour.....2 minute.....P.M.

21. I hereby certify that I attended the deceased from.....12-31, 1945 to.....1-7, 1946
that I last saw him alive on.....17, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death.....Carcinoma Esophagus

Due to.....Ho

Due to.....

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

Duration
undeter

Major findings:
Of operations.....Melotoni

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?.....

While at work..... (Specify type of place) (d) Means of injury.....

23. Signature.....Willie [Signature] (M. D. or other).....MD

Address.....4503 Page Ave. Date signed.....

MAR 8 1946

STATEMENT BY LICENSED EMBALMER

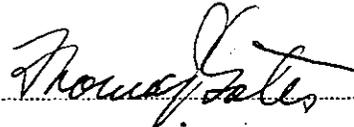
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Thomas J. Gates

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....



Licensed Embalmer No..... 4259

P. O. Address..... 4107 Finney Ave.

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.