

No. 2
1-5-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16594

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2207

1. PLACE OF DEATH:

(a) County JACKSON

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

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

(d) Length of stay: In hospital or institution 5 MONTHS
(Specify whether years, months or days)

In this community 28 YEARS
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON ⁴⁸

(c) City or town KANSAS CITY ³
(If outside city or town limits, write "RURAL")

(d) Street No. 7022 PROSPECT AVENUE ^F
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No) ⁰

If yes, name country

3. (a) PRINT FULL NAME MRS. SADIE WEISS COCHRAN

3. (b) If veteran, name war No

3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE

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

6. (b) Name of husband or wife MR. GAYLORD COCHRAN

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

7. Birth date of deceased JANUARY 25 1883
(Month) (Day) (Year)

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

63 3 19 hr. min.

9. Birthplace BUFFALO MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business

12. Name ARAM WEISS

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

14. Maiden name NANCY SHIVELY

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

16. (a) Informant MR. WILBERT L. WEISS

(b) Address SANTA ANA CALIFORNIA

17. (a) BURIAL (b) Date thereof MAY 17 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT. WASHINGTON CEM.

18. (a) Signature of funeral director W. J. Macomber Sons

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 5-17-46 (b) Sheldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 14 TH
year 1946 hour 12 minute 35 P. M.

21. I hereby certify that I attended the deceased from DEC. 21 1945 to May 14 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 4 days

Due to Hypertension ?

Due to Arteriosclerosis ?

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

Major findings: --- ⁸³⁰

Of operations ---

Of autopsy ---

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? ---

White at work? --- (Specify type of place) (e) Means of injury ---

23. Signature Lynan Richardson (M. D. or other) ⁰
Address 1320 Professional Bldg Date signed 15 May 46

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

MOTHER FATHER

1220 Copied

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 Emile M. Calhoun

Licensed Embalmer No. 3506

P. O. Address Ke Mio.

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.