

No. 2
1-17-39
5-17-39

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

19602

State File No.

Registrar's No. 1074

FILED MAY 23 1947

3069

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Richmond Heights, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Marys Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 Days
(Specify whether
In this community 45 Years
years, months or days)

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. 310 No. Skinker Blvd.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Virginia A. Cochrane
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F. 5. Color or race W. 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: April 26, 1888
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	59	0	16	hr. min.

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

10. Usual occupation: Millinery Designer

11. Industry or business

12. Name: Thomas E. Cochrane

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

14. Maiden name: Sarah Kirby

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

16. (a) Informant: Catherine Cochrane
(b) Address: 310 No. Skinker Blvd.

17. (a) Burial (b) Date thereof: 5-16-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation: Calvary Cemetery

18. (a) Signature of funeral director: Arthur Donnelly
(b) Address: 3840 Russell Blvd

19. 45-14-47 (b) Carroll J. [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 12 year 1947 hour 8 minute 45 P.M.
21. I hereby certify that I attended the deceased from 5 May 1947 to 12 May 1947
that I last saw him alive on 12 May 1947 and that death occurred on the date and hour stated above.
Duration

Immediate cause of death: Cerebral vascular hemorrhage
Due to: Cerebral arteriosclerosis Hypertension

Due to: Arteriosclerosis generalized Hypertension
Other conditions: 30 g
(Include pregnancy within 3 months of death)
Syphilis, latent, tertiary

Major findings: Syphilis, latent, tertiary
Of operations:
Of autopsy:
PHYSICIAN
Underline the cause of 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)
(e) Means of injury
Signature William F. Knight Jr. (M. D. or other)
Address Mo. Theater Bldg Date signed 13 May 47

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

MOTHER FATHER

11-1
MAD'S BIRD

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..... *W Van Matre*

Licensed Embalmer No. *2825*

P. O. Address. *4340 Lafayette*

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.