

No. 2
-12-45
5-17-39
P. I. X47070

FILED AUG 16 1947

Registration District No. 3

Primary Registration District No. 3069

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
At Home 1020 Blendon Place
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 1 YEAR (Specify whether _____)
(Years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

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

(d) Street No. 1020 Blendon Place
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME ALEXANDER H. COCHRAN

3. (b) If veteran, name war _____ 3. (c) Social Security No. NONE

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Maud Cochran 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased April 21st 1876
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>71</u>	<u>3</u>	<u>13</u>	<u>12</u> hr. _____ min.

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

10. Usual occupation Railroad Clerk

11. Industry or business _____

12. Name James Cochran

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

14. Maiden name Elizabeth Hamilton

15. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. A. H. Cochran

(b) Address 1020 Blendon Pl

17. (a) Burial (b) Date thereof Aug. 7 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Watson Backlage

(b) Address 6536 Clayton Rd.

19. (a) 8-8-47 (b) W. Backlage
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 4 year 1947 hour 12 minute 10 P M.

21. I hereby certify that I attended the deceased from January 1946 to Aug 4 1947
that I last saw him live on Aug 3rd 1947
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Asystolic Paralysis Duration 8 Mo.

Due to Myocardial Arterio-sclerosis 18 Mo.

Due to _____

Other conditions 82!
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

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 0

23. Signature W. Backlage (M. D. or other) _____

Address 19 E. Lockwood Date signed 8/3/47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1901 87 9011

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 J Allen Davis Jr
Licensed Embalmer No. 4053
P. O. Address St Louis Mo

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.