. No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED JAN 26 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 195

Registration District No. 42 | Primary Registration District No. 1000 | Registrar's No. 75

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mo. Methodist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 1 month (Specify whether years, months or days)
In this community: Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: Buchanan 11
(c) City or town: Rural St. Joseph 0
(If outside city or town limits, write "RURAL")
(d) Street No.: R.F.D.#3, Karnes Road 0
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No) 1
If yes, name country:

3. (a) PRINT FULL NAME: Hattie A. Cochran
3. (b) If veteran, name war: no
3. (c) Social Security No.: none
4. Sex: Fem
5. Color or race: Wht
6. (a) Single, widowed, married, divorced: widowed
6. (b) Name of husband or wife: unk
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: June 27 1876 (Month) (Day) (Year)
8. AGE: Years 72 | Months 6 | Days 17 | If less than one day: hr. min.
9. Birthplace: St. Joseph (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: at home
11. Industry or business:
FATHER 12. Name: Charles Groscup
13. Birthplace: New York City (City, town, or county) New York (State or foreign country)
MOTHER 14. Maiden name: Mary M. (unknown)
15. Birthplace: unknown (City, town, or country) Michigan (State or foreign country)
16. (a) Informant: Mrs. Raymond Mueller
(b) Address: Karnes Rd., St. Joseph, Mo.
17. (a) burial (Burial, cremation, or removal) (b) Date thereof: 1-16-48 (Month) (Day) (Year)
(c) Place: burial or cremation: Ashland Cemetery
18. (a) Signature of funeral director: Clausing Funeral Home
(b) Address: St. Joseph Mo
19. (a) 1-24-48 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month January day 14 year 1948 hour 4 minute P.M.
21. I hereby certify that I attended the deceased from December 15 1947 to January 14 1948 and that I last saw her alive on January 14 1948 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hypertensive Heart Disease with Congestive failure	Ukn.
Due to: xxxx	
Due to: Other Conditions: Chr. Glomerular Nephritis	Ukn.
Other conditions (Include pregnancy within 3 months of death): Generalized Arteriosclerosis	Ukn.

Major findings:
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? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: [illegible] (M. D. or other)
Address: The Tootle Building St. Joseph, Mo. Date signed 1-15-48

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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 Charles M. Harman, Registered Apprentice No. 450, working under my personal supervision.

Signed John Roy Stoney

Licensed Embalmer No. 2435

P. O. Address St Joseph

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.