

FILED NOV 8 1948
228

Primary Registration District No. 2000

Registrar's No. 962

1. PLACE OF DEATH:

(a) County Greene

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

(c) Name of hospital or institution: O'Reilly V A Hospital 1)
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 27 days
(Specify whether _____)

In this community 27 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Oklahoma (b) County Logan 999 340

(c) City or town Guthrie
(If outside city or town limits, write "RURAL") 2

(d) Street No. 207 E. Springer
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3: (a) PRINT FULL NAME Jessie Cochran

3. (b) If veteran, name war WW II

3. (c) Social Security No. 442 12 1462

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 3
year 1948 hour 9 minute 10 P. M.

4. Sex Male 2

5. Color or race Colored

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

6. (b) Name of husband or wife Letha Mae Cochran

6. (c) Age of husband or wife if alive 33 years

7. Birth date of deceased: July 10 1911
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from October 7 1948 to November 3 1948; that I last saw him alive on November 3 1948; and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis, pulmonary, chronic, reinfection type, far advanced, active.

Duration _____

8. AGE: Years Months Days If less than one day
37 3 23 hr. _____ min.

Due to _____

Due to _____

9. Birthplace Meridian, Oklahoma
(City, town, or county) (State or foreign country)

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

10. Usual occupation Student

Major findings: Of operations _____

Of autopsy: _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

11. Industry or business None

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 VA Hospital Records

(b) Address Springfield, Missouri

17. (a) Removal (b) Date thereof 11-4-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Guthrie, Okla

18. (a) Signature of funeral director German Schaff Funeral Home

(b) Address Springfield, Mo

19. (a) 11-9-48 (b) N. E. Hardley MD
(Date received local registrar) (Registrar's signature)

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 Paul Eisele (M. D. or other) MD
Address O'Reilly VAH Springfield Mo Date signed 11-4-48

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

MOTHER FATHER

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 _____

Gene L. Hunter

Registered Apprentice No. *291*

working under my personal supervision.

Signed *Lewis G. Schaff*

Licensed Embalmer No. *3802*

P. O. Address *Springfield, M.*

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.