

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29586**

FILED SEP 19 1949

BIRTH NO. _____		REG. DIST. NO. 58		PRIMARY REG. DIST. NO. 489		Registrar's No. 28	
1. PLACE OF DEATH a. COUNTY CARTER				2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission). a. STATE MISSOURI b. COUNTY CARTER			
b. CITY (If outside corporate limits, write RURAL and give township) GRANDIN				c. CITY (If outside corporate limits, write RURAL and give township) GRANDIN			
d. FULL NAME OF HOSPITAL OR INSTITUTION 1				d. STREET ADDRESS (If rural, give location) 10			
3. NAME OF DECEASED (Type or Print) William		a. (First) J.		b. (Middle) Cochran		c. (Last)	
4. DATE OF DEATH 8-18-1949		5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	
8. DATE OF BIRTH 3-8-1868		9. AGE (In years last birthday) 81		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE MARY Alice Cochran	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME NEVA BURNS-GRANDIN ADDRESS Mo.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) GANERENE BOTH FEET				INTERVAL BETWEEN ONSET AND DEATH 5 MONTHS			
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DIABETE MELLITUS				? YEARS			
DUE TO (c)							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				261X			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 21 July , 19 49 , to 18 August , 19 49 , that I last saw the deceased alive on 21 July , 19 49 , and that death occurred at 10:20 p.m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) M.D. D.				23b. ADDRESS Doniphan, Mo.		23c. DATE SIGNED 27 Aug. '49	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 8-20-1949		24c. NAME OF CEMETERY OR CREMATORY GRANDIN Cemetery		24d. LOCATION (City, town, or county) (State) Grandin Mo	
DATE REC'D BY LOCAL REG. Sept. 8-49		REGISTRAR'S SIGNATURE Mrs. Oeta Henderson		25. FUNERAL DIRECTOR'S SIGNATURE L.W. Edwards		ADDRESS Doniphan, Mo.	

(Licensed Embalmers' Statement on Reverse Side)

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

RECEIVED 9/13/49
District Health Officer No. 5,
District File Number 949618
Date Filed 9/15/49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Carl B Bird

Signed _____
Student Embalmer

Licensed Embalmer No. 4306

P. O. Address Doniphan, 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.