

FILED NOV 6 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34293

BIRTH NO. 35259-50 REG. DIST. NO. 264 PRIMARY REG. DIST. NO. 4394 Registrar's No. 33

1. PLACE OF DEATH a. COUNTY Ozark		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Ozark	
b. CITY (If outside corporate limits, write RURAL and give township) Bakersfield		c. CITY (If outside corporate limits, write RURAL and give township) Bakersfield 0770	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (First) Lillian (Middle) Ann (Last) Cockrum			4. DATE OF DEATH (Month) 9 (Day) 25 (Year) 50		
5. SEX F	6. COLOR OR RACE W.H.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) N.M.	8. DATE OF BIRTH June 4-1950		9. AGE (In years last birthday) 3 6 Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Bakersfield Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME Harold P. Cockrum		13b. MOTHER'S MAIDEN NAME Norma Jean Howard		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Norma Jean Cockrum	
				ADDRESS Bakersfield Mo.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Infections Cataracted Jaundice		DUPLICATE DUE TO (b) Probably Congenital		3 Mo	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		092X	

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)		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on 9-25, 1950, and that death occurred at 2:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE H. J. Hoernow D.D. (Degree or title) Croner		23b. ADDRESS Linnville, Mo.		23c. DATE SIGNED 10-26-50	
24a. BURIAL CREMATION, REMOVAL (Specify) B		24b. DATE 9-28-1950		24c. NAME OF CEMETERY OR CREMATORY First Union Cem. Howell Co. Mo.	
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE William Cogwell 405		ADDRESS West Plains, Mo.	
DATE REC'D BY LOCAL REG. 10-26-50		REGISTRAR'S SIGNATURE William Cogwell			

(Licensed Embalmer's Statement on Reverse Side)

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

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DIVISION OF HEALTH OF MO.

District No. 5 - Springfield

RECEIVED NOV 1 1950

Dist. File 1150-2220

Date Filed 11-1-50

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 _____

Signed _____
Student Embalmer

Licensed Embalmer No. 4547

P. O. Address _____

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.