

28134

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

7138

No. 300

10.48

FILED AUG 25 1951

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>1-wk.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		<u>2059</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>DePaul Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>310 N. Skinker</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Sarah</u> b. (Middle) <u>A.</u> c. (Last) <u>Cochrane</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 9, 1951</u>				
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W.</u>	8. DATE OF BIRTH <u>Oct. 17, 1869</u>	9. AGE (In years last birthday) <u>81</u>	10. UNDER 1 YEAR Months <u>9</u> Days <u>22</u>	11. UNDER 24 HRS. Hours <u>22</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Thomas E. Cochrane</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Kirby</u>		14. NAME OF HUSBAND OR WIFE <u>Thomas E. Cochrane</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Miss Kathryn E. Cochrane, 310 N. Skinker</u>			
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>arteriosclerotic heart disease</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Co</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4200</u>				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 <u>1945</u> to <u>8-9</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>8-9</u> , 19 <u>51</u> , and that death occurred at <u>5:10 pm.</u> from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>D.B. Hovan M.D.</u>				23b. ADDRESS <u>539 N. Grand</u>		23c. DATE SIGNED <u>8/10/51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug. 11, 1951</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>Aug 10 1951</u>				25. GENERAL DIRECTOR'S SIGNATURE ADDRESS <u>Arthur J. Donnelly 3840 Lindell Blvd.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

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 me

working under my personal supervision.

Student Embalmer No. ....

Signed

*Wm S Deffen*

Signed.....  
Student Embalmer

Licensed Embalmer No. 4699

P. O. Address St Charles, 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.